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ABSTRACT

This publication of the New York Counseling Association is dedicated to providing in-depth articles about research on topics relevant to the profession. It is designed for use by professionals working in schools, colleges, and agency settings. The 1999 volume comprises two issues. Issue 1 is devoted to the topic of play therapy. Articles include: "Play Therapy Special Issue" (E. Goldin); "Introduction to the Special Issue" (J. Cerio); "Curative Factors in Play Therapy" (C. E. Schaefer); "Typical Stages in the Child-Centered Play Therapy Process" (W. J. Nordling; L. Guernsey); "Client-Centered Play Therapy Techniques for Elementary School Counselors: Building the Supportive Relationship" (E. Phillips; J. Mullen); "Developmental Considerations in Play and Play Therapy with Traumatized Children" (A. Drewes); "Play Therapy Training Practices for School Counselors: Results of a National Study" (J. Cerio; T. Taggart; L. Costa); "A Comparison of the Effects of Two Family Play Therapy Activities on Child Participation, Comfort, and Activity Preference in Family Therapy" (K. L. Giudici; J. Cerio); and "Future Directions in Play Therapy Research" (J. Cerio; H. Boehm-Morelli). Articles in Number 2 include: "Message from the President" (J. A. Bayle); "Observations as the Profession Approaches the Turn of the Century" (E. Goldin); "Youth Gangs: A Counselor's View" (T. M. Batsis; J. S. Koshi); "Stalking Behavior: Love and Delusion" (D. Farrugia); "School to College Transition Programs: Straight Talk about Alcohol and Sex" (J. M. Gibson); "Capturing the Teachable Moment in Counseling" (B. B. Kahn); "Media Strategies for Counseling Professionals" (J. Gill-Wigal; S. A. Gallagher Warden; M. R. Schlarb); "The Diagnostic Dilemma: Implications and Concerns for Use of the DSM-IV in a College or University Counseling Center" (S. Hodges); "An Empirical Study of College Students' Grief Responses: Death vs Non-Death Losses" (D. A. Cohen); and "Power Plays: Their Use and Abuse in Human Relations" (book review by D. L. Araoz). (Contains numerous references.) (JDM)

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Volume 14, Number 1

Spring 1999

Special Issue: PLAY THERAPY

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Eugene Goldin

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“ *Play is the child's natural
medium of self expression.* **”**
-VIRGINIA AXLINE

From the Editor: Play Therapy Special Issue:

Eugene Goldin

While a graduate student in counseling in the early '70s, I was fortunate to have read two extraordinary books by Virginia Axline, *Play Therapy* (1947) and *Dibbs: In Search of Self* (1964). As a counselor intern, my first client was a child. Using play therapy techniques, I was able to successfully reach this client. Nevertheless, the course of my counseling career took me away from working with children. As a result, I rarely had an opportunity to continue utilizing play therapy interventions with my clients. However, I never forgot about these books and the potential benefits of employing play therapy in counseling. Thus, when Jay Cerio approached me with the idea of creating a special issue of the *Journal for the Professional Counselor* entirely devoted to play therapy, I was completely overjoyed. The issue you are about to read has taken two years to develop. It contains theory, practice and research articles that accurately represent the current state of play therapy. Jay Cerio is to be congratulated for making a significant contribution to our profession.

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“ *Man is perfectly human
only when he plays.* **”**
-SCHILLER

Introduction to the Special Issue

Jay Cerio

Play therapy is a therapeutic approach, the origins of which can be traced back to the early days of the psychotherapy field. Beginning with Hug-Helmuth (1921), play has been used in counseling and psychotherapy in a variety of ways from simply being a means of increasing children's comfort in the counseling situation (Freud, 1946), to being the primary focal point of therapy (Klein, 1955). In reality, play therapy is not a singular approach, just as "talking" therapy with adults is not one approach. Play therapy is, instead, a modality that encompasses many approaches and theoretical viewpoints.

Interest in play therapy has waxed and waned over the 80 years of its existence. However, during the past 15 years, there has been a resurgence in the use of play therapy in school and mental health settings. This re-emergence of play therapy is very likely due to significant increases in the identification of abused children, fueled by mandated reporting laws that went into effect in the late 1970's and early 1980's. This, in turn, rekindled interest in the welfare of children and child mental health. Confronted with this large population of traumatized clients whose problems tended to be more internal than behavioral, counselors began looking for alternatives to the behavioral and talking approaches that had become so popular in the 1960's and 70's. Play therapy seemed to fit this need, as it relies much less on verbal skills, allowing children to express themselves using the common tools of childhood—toys, games, and fantasy.

With this increased interest in play therapy came a concomitant increase in publications, training opportunities, and research. Texts were authored by several of the major figures in the field (Gil, 1991; Landreth, 1991; O'Connor, 1991); a major professional association, the International Association for Play Therapy, was founded in 1982; and a journal, *The International Journal of Play Therapy*, became an outlet for current theory, research, and professional issues of the field. Several centers were also established, such as the Center for Play Therapy and National Institute for Relationship Enhancement, that offered regular training opportunities for individuals interested in becoming play therapists.

This special issue of *The Journal for the Professional Counselor* is designed to provide our readers with an overview of the current state of play therapy. In developing this issue, I have attempted to provide a sampling of play therapy from a variety of perspectives. Articles by Schaefer, and Nordling and Guerney, prominent figures in the field, discuss therapeutic phenomena they have observed in their decades of experience as play therapy practitioners. Phillips and Mullen, and Drewes present ideas regarding issues and approaches to play therapy. Finally, Cerio, Taggart, and Costa, and Guidici and Cerio provide findings of two research projects: one on play therapy training and the other on a widely used play therapy technique, respectively. It is my hope that this issue will serve as a useful reference for practitioners, trainers, and students in the counseling field

I would like to thank the small, hardworking group of ad hoc reviewers who contributed to this project. Their careful consideration of articles and editorial feedback were vital in producing this issue. These reviewers were:

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Curative Factors in Play Therapy

Charles E. Schaefer

As a first step in understanding the therapeutic forces in play therapy, a nonhierarchical taxonomy of 25 change agents in play is presented. It is suggested that play therapy is most effective when the therapist applies these change mechanisms differentially to meet the needs of the individual case. The usefulness of this proposed taxonomy needs to be evaluated by further study.

Introduction

One of the most challenging issues in play therapy today is identifying what actually produces change in the client during treatment. What are the invisible but powerful forces resulting from the therapist-client play interactions that help the client to overcome psychological difficulties and grow as a person. A greater understanding of these change mechanisms should enable the play therapist to apply them more effectively to meet the particular needs of a client. The prescriptive approach to play therapy is based upon an individualized, differential, and focused matching of curative powers to the specific problems of a patient (Kaduson, Cangelosi, & Schaefer, 1997).

The curative factors in psychotherapy have long been of interest to therapists of different theoretical orientations. According to Freud, psychoanalytic cure results from insight, facilitated by the therapist's interpretations and analysis of the transference (Slipp, 1982). Other psychodynamic and humanistic theorists have emphasized the importance of the patient-therapist relationship. Carl Rogers (1957), for example, believed that the necessary and sufficient conditions of therapeutic change were embedded in the therapist attributes of genuineness, warmth, and respect for the client. Yalom (1985) described ten change mechanisms inherent in group psychotherapy which he labelled "therapeutic factors", namely: 1. acceptance, 2. altruism, 3. catharsis, 4. instillation of hope, 5. interpersonal learning, 6. self-disclosure, 7. self-understanding, 8. universality, 9. vicarious learning, 10. guidance. Finally, Bergin and Strupp (1972) identified ten active ingredients that cut across

various schools of psychotherapy: (a) counter-conditioning, (b) extinction, (c) cognitive learning, (d) reward and punishment, (e) transfer and generalization, (f) imitation and identification (g) persuasion, (h) empathy, (i) warmth, and (j) interpretation.

The purpose of this article is to provide play therapy practitioners with a guide to 25 primary therapeutic powers of play therapy. These factors have been identified through an extensive review of the existing play therapy and related literature. A discussion of each therapeutic power and its usefulness in play therapy is provided in the next section.

Curative Powers of Play

(1) Self-Expression: Young children (ages 2 to 10) often have difficulty expressing their conscious thoughts and feelings because of their rudimentary vocabulary and limited abstract thinking ability. Typically they are much more comfortable expressing their internal states through concrete play activities and materials (Landreth, 1993). Moreover, on sensitive issues like sexual abuse, play allows children to express themselves indirectly through anatomical dolls, puppets, and miniature objects. Such indirect expression affords the child some psychological distance from the hurtful feelings.

2) Access the Unconscious: Toys and games provide a familiar, neutral stimulus onto which children can reveal unconscious conflicts through such defense mechanisms as projection, displacement, and symbolization (Klein, 1955). "Play work", according to Elkind (1981), is the mental process that transforms unacceptable, unconscious wishes and impulses into acceptable but often hard to understand conscious play images and actions. "Play work" is to the child what "dream work" is for the adult (Elkind 1981). Through interpretations, the play therapist attempts to bring such unconscious material into conscious awareness.

3) Facilitates Learning: In the field of education there is a long history of using play to help children learn (Axline, 1947b; Bills, 1950; Marbach & Yawkey, 1980; Pumfrey & Elliott, 1970; Silvern, Williamson & Waters, 1983). Similarly, play therapists can use play to teach children more adaptive thoughts and behaviors, such as social skills. Since play is a very enjoyable activity, children's interest and attention to a learning task is enhanced. The active involvement of a child in play also assists the teaching of social/emotional skills.

4) Metaphorical Insight: Since ancient times stories have been used to teach children. In interactive fantasy play, the therapist tells a story through the play to teach a child a lesson or solution to his/her problem (Gardner, 1971).

Since stories teach indirectly, less defensiveness is aroused in the child than by direct confrontation (Frey, 1993).

5) **Abreaction**: In play, children will reenact and relive traumatic experiences as a means of gradually mentally digesting and gaining mastery over them (Waelder, 1932). Adults tend to "talk out" unpleasant experiences, such as an operation, while children play them out. There is a slow healing process through the repetitive play (Oremland, 1993).

6) **Catharsis**: Pent up physical and psychological tension can be released in the play room by engaging in concrete play activities such as punching an inflated plastic doll, pounding clay, or bursting balloons. Catharsis is an activity that involves completing some or all of a previously restrained or interrupted sequence of self-expression, such as crying or hitting (Nichols & Efran, 1985). The importance of emotional release is acknowledged by most psychotherapists as an essential, if not the essential, ingredient in psychotherapy (Ginsberg, 1993).

7) **Sublimation**: One way to release unacceptable impulses is to channel them into substitute activities which are socially acceptable. For example, the aggressive impulses of clients who tend to physically hit others may be reduced by therapists who facilitate the expression of these impulses in "war-like" board (Chess, Checkers) or card games (Fine, 1956), or through such sports activities as bowling or football. The original impulse is never conscious in sublimation.

8) **Alliance Formation**: Numerous studies have found that a major factor distinguishing poor therapy outcome from good outcome is the therapist's ability to establish a good therapeutic alliance with his or her clients (Bordin, 1989; Gaston, 1990; Horvath, 1991). Children rarely come voluntarily to therapy and typically feel very uncomfortable in one-to-one talk therapy with an adult. Play, on the other hand, is an attractive voluntary activity of children and is usually enough to overcome a child's initial reluctance to become involved in the therapy process (Bow, 1993).

9) **Attachment**: Play has been found to facilitate the attachment (affectional bond) between parent and child. Studies have found that mothers who regularly involve their infants in play and appear to enjoy doing so - are the most likely to have securely attached children (Blehar, et al, 1977). In the theraplay approach (Jernberg, 1979), play therapists teach parents how to use interactive, sensory-motor play to bond with children with attachment problems.

10) **Relationship Enhancement**: Shared experiences like playing and having fun tend to increase our liking for the other person. Various studies have found that positive affective experiences, such as playing together, increase

mutual attraction and solidify relationships (Gouaux, 1971). Fun and enjoyment are conjunctive emotions: They bring people together and facilitate friendships. By teaching play skills to socially isolated children, therapists can increase the social attractiveness of these children.

11) Moral Judgment: Piaget (1932) asserted that children's spontaneous rule making and rule enforcing in informal and unsupervised play situations, e.g., deciding what is fair in a game of marbles, provide a crucially important experience for the development of mature moral judgment. Such game play experiences help children move beyond the early stage of moral realism, in which rules are seen as external restraints arbitrarily imposed by powerful adult authority figures, to the concept of morality based on the principles of cooperation and consent among equals.

12) Stress Inoculation: By playing out upcoming stressful events, such as starting school or the birth of a sibling, children are able to make the strange event become more familiar and role play coping behaviors (Barnett, 1984; Field & Rite, 1984; Kramer & Schaefer-Hernan, 1994). Also, studies have shown that positive emotions, such as enjoyment derived from play, have a mitigating effect on subsequent negative experiences (Carlson & Masters, 1986). So the more happy, fun times a child has, the better able the child is to cope with the subsequent stresses of life.

13) Counterconditioning: Wolpe (1958) used the term *reciprocal inhibition* to refer to the phenomenon that certain internal states are mutually exclusive. Anxiety and relaxation cannot be experienced at the same time. Similarly, feelings of mirth and playfulness can be used to counteract and overcome such negative feelings as anxiety or depression. Thus, the fun of playing hide-and-seek in a darkened room can help a child conquer the fear of the dark. Similarly, playing video games can aid a child to conquer anxiety experienced in a dentist's office. Moreover, research has found that hospitalized children who were given the opportunity to engage in dramatic play with hospital-related toys, showed a significant reduction in hospital specific fears (Rae, et al, 1989). According to Lyness (1993) fantasy play has a number of particular features that promote the mastery of children's fears. It allows the child to move from a passive to an active role, e.g., child can role play giving an injection to a doll patient. Fantasy play also facilitates the expression of several defense mechanisms such as, projection, displacement, repetition and identification.

14) Power/Control: In play, children feel powerful and in control. They can make the play world conform to their wishes and needs. According to Piaget (1962), it is ego-boosting to the child to be able to dominate and control the play action. Usually children have very little control over what happens in

their lives. Play is one area in which they can make things happen all by themselves and thus develop an internal locus of control.

15) **Competence:** White (1971) defined competence as being able to meet the demands of a situation or task. Play provides children with many opportunities to create things (tell stories, construct miniature worlds in the sand) and meet challenges through competitive and cooperative games. By mastery of play activities, children develop a sense of competence which enhances their self-esteem.

16) **Self-Control:** By engaging in activities such as construction play and game play, children learn self-control skills, i.e. to stop and think, plan ahead, and anticipate consequences of different moves. Also, cognitive psychologists claim that fantasy play is a cognitive skill associated with the ability to control impulses and to delay gratification (Singer, 1961; Singer & Singer, 1990).

17) **Creative Problem Solving:** Numerous studies have demonstrated that play and playfulness are associated with increases in creativity and divergent thinking in children (Lieberman, 1965; Feitelson & Ross, 1973; Wallach & Kogan, 1965). Without concern for consequences, children in play attend to means rather than ends and thereby come up with novel combinations and discoveries which can aid them in solving personal and social problems (Bruner, 1983; Sawyers & Horn-Wingerd, 1993).

18) **Fantasy Compensation:** In play, children can get immediate substitute gratification of their wishes. A fearful child can be courageous, a weak child can be strong, a child of poverty can be a rich king, and a handicapped child can be whole. According to Robinson (1970), play is essentially a compensatory mechanism which has the same origin and impetus as the daydream. Thus, impulses and needs which are blocked expression in real life find an outlet in fantasy. Similarly, Huizinga (1955) believed that the main function of play is to allow one to imagine something else - something that is often more beautiful, or stronger, or more exciting.

19) **Reality Testing:** Play experiences give children practice reading cues which signal make-believe. In social pretend play, children often shift back and forth between the roles they are playing and their real selves. Thus, children who frequently engage in pretend play have been found to be better able to discriminate reality from fantasy (Singer, & Singer 1990).

20) **Empathy:** When children role play, they develop their capacity for empathy - the ability to see things from another's perspective. Role playing different characters in play has been reported to be related to increased altruism (Iannotti, 1978), empathy (Strayer & Roberts, 1989), and social competence in children (Connolly & Doyle, 1984).

21) Behavioral Rehearsal: In the safe environment of play, children can practice more socially acceptable behaviors, such as assertiveness versus aggressiveness. The play therapist often models in play these new real life behaviors through puppets, and the child then has his puppets practice the more adaptive behaviors. This practice can be repeated many times in play to ensure that the skill is fully learned and will be remembered (Jones, Ollendick & Shenskl, 1989).

22) Accelerated Development: Vygotsky (1967) observed that in play preschoolers advance beyond the ordinary accomplishments of their age period and function at a level of thinking that will only become characteristic later on. He noted that the preschool child in play is always above his average age, and above his daily behavior. Accordingly, play creates what he labeled "the zone of proximal development of the child" (Vygotsky, p.76).

23) Sense of Self: In child-centered play therapy, (Axline, 1947) the child experiences complete acceptance and permissiveness to be himself (without evaluation or pressure to change). By giving a running commentary on the child's play the therapist provides a mirror, figuratively speaking, by which the child can understand inner thoughts and feelings. In addition to self-awareness, play provides the child an opportunity for self-creation, i.e. to realize the power within herself to be an individual in her own right, to think for herself, to make her decisions, to discover herself (Winnicott, 1971). Since this is often a unique experience, Meares (1993) noted that the field of play is where, to a large extent, a sense of self is generated. Meares concluded that play with an attuned adult present is where experiences are generated that become the core of what we mean by personal selves.

24) Physical Health: Stress has been shown to create unhealthy physiologic pressure, muscle tension, immunosuppression, and many other physical problems (Berk, Tan & Fry, 1989). We now have evidence that laughter creates the opposite effect (Fry, 1991). Laughter appears to be a perfect antidote for stress. Research has discovered that the experience of laughter releases mood boosting hormones - endorphins, lowers serum cortisol levels and stimulates the immune system (Berk, 1989).

25) Distraction: When children are involved in activities such as play they tend to feel less anxious or depressed. Enjoyable activities function as distractions and contribute to a greater sense of well-being and less distress (Aborn, 1993). Glyshaw, et al. (1990), for example, found that "going to movies", "going shopping", and "going to parties" was anxiety-reducing for junior high students. By taking regular "play breaks", children and adults are likely to elevate their mood and sense of well-being.

Conclusion

The wide spectrum of change mechanisms described above suggests that the domain of therapeutic powers is well represented. The play therapist must view these change mechanisms not as mysterious influences, but as factors that can be understood and altered, if not fully controlled. Individualized treatment goals will guide the therapist as to which therapeutic powers to apply. The trend in the field is to combine the change agents in play to optimize treatment effectiveness.

In the past, play therapists have paid much more attention to developing a particular theoretical approach, such as cognitive-behavioral principles, rather than to identifying discrete elements of the play process that seem to account for clinical improvement. It is time to look inside the black box to more fully understand the change agents in play itself. A clearer knowledge of the array of therapeutic factors underlying play therapy will allow child clinicians to borrow flexibly from available theoretical positions to tailor their treatment to a particular child (Kaduson, Cangelosi, & Schaefer, 1997). The taxonomy presented above is based on past research and clinical observations. The practical (or ecological) validity of this formulation still needs to be tested against the experiences of play therapists in the field. In addition, rigorous empirical studies would help determine which individual factors and combinations of factors are most operative in play therapy. For now, this conceptualization of the 25 primary therapeutic powers can serve as a general map for play therapy practitioners.

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Typical Stages in the Child-Centered Play Therapy Process

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Louise F. Guerney

The identification of stages in the play therapy process has received only modest attention in the play therapy research (Moustakas, 1955; Hendricks, 1971; Withee, 1975). Indeed, in the case of the Child-Centered play therapy model - an approach in which the child, not the therapist, takes a leadership role in determining the content of the sessions - it may appear as counterintuitive that any regular and predictable stages in the play therapy process could be identified.

However upon even cursory examination of the Child-Centered play therapy model, it is evident that in spite of the infinite variety of play content which emerges as children take leadership roles in play sessions, there is generally a pattern of consistency, uniformity, and predictability in the way in which children express themselves at different times throughout the play therapy process. Specifically, children tend to display different behaviors and work on different therapeutic issues at different times or "stages" in the therapeutic process. In this article, the authors will attempt to outline these play therapy stages. However, the reader should keep in mind that this "stage" framework for assessing therapeutic process, although often a useful way of organizing session data and making sense of the therapeutic process, is nevertheless only a conceptual framework and not at the level of "scientific law" or "cause and effect." A small percentage of children do not go through the stages in the order which we will lay out; indeed, a few children do not go through the stages at all. Even in the majority of those children that do go through the stages, there is great variation in terms of how long a given child will spend in each stage of the process.

With this said, it is important to note that the "stage" process we will outline can be useful in making sense of sessions, tracking progress on a session by session basis, determining when it is appropriate to terminate sessions, and making us aware of when the CCPT model does not seem to be working for a given child.

The Four Stages of the Child-Centered Play Therapy Process

The authors propose a four stage model for understanding the therapeutic process of children participating in Child-Centered play therapy. These stages are the "warm-up" stage, the "aggressive" stage, the "regressive" stage, and the "mastery" stage. Each "stage" of the therapeutic process is a way of conceptualizing a broad array of data which Child-Centered play therapists observe throughout the therapy process. In short, during a specific "stage" a child tends to display a certain set of typical behaviors, and certain themes and therapeutic issues tend to emerge. As the child progresses through the stages the child's relationship with the therapist strengthens. Before beginning to describe the stages, however, it should be noted that the proposed stage model offered here is likely to become less applicable as a given play therapist's approach deviates from the theory, methods, and techniques which make up the Child-Centered play therapy model.

The "Warm-up" Stage

The "warm-up" stage is the first stage of the therapeutic process. During this stage the child orients himself to the playroom, develops a basic sense of trust and comfort in being with the therapist, begins to understand the quality of permissiveness which characterizes the playroom, and adopts the leadership role which is central to Child-Centered play therapy.

Typical behaviors observed during this stage include the child's exploration of the playroom and the toys contained in it, as well as questioning the therapist about what things the child can and cannot do in the playroom. Frequently the child will move from one toy to another, trying one out and then moving on to the next. Play with the toys in the playroom at this stage is usually less focused, more time-limited, and contains considerably less projective material than in the later stages of the play therapy process.

Many children, especially those who are experiencing problems with impulsivity and oppositional behaviors, will begin to understand the permissiveness of the playroom during this stage and will take full advantage by seeking to discover what limits do exist in the playroom. The variety of limit testing behaviors is quite diverse but often includes experimenting with minor aggressive acts toward the therapist in role play situations, making a

mess, "swearing," and trying to take things from the playroom. Through such limit-testing, the child discovers that almost all imagined limits are absent except for actual injury to self or therapist or real damage to property.

During the "warm-up" stage, children who are anxious, perfectionistic, overcontrolled, or who are experiencing separation anxiety may initially be quiet, inhibited, and uncertain as to what their role is in the playroom. Such children may attempt to get the therapist to take over the leadership role in the play sessions. Through the therapist's use of frequent empathy and structuring responses and implicit refusal to take the leadership role, such children frequently "warm-up" by the end of even the first session and move from passiveness and quietness to active exploration and some verbal interaction with the therapist.

As with any of the other stages, the "warm-up" stage may vary greatly in its duration from one child to the next. For some children the basic activities of exploration, understanding the permissiveness of the playroom, and adopting the leadership role may be complete at the end of the first session or two. However, the development of trust toward and security with the therapist which is necessary for entering into to work on central therapeutic issues often takes more time, especially for children whose core problems center on attachment issues.

In summary, the "warm-up" stage is that part of the therapeutic process in which children explore, orient themselves, test limits, begin to understand how their role and the therapist's role in the playroom differ from other environments, adopt a leadership role in the playroom, grow more comfortable and flexible in their self-expression, and develop the trust and security necessary for further therapeutic work to commence.

The "Aggressive" Stage

Once trust and security have developed in the therapeutic relationship, the child can begin work on the central therapeutic issues which underlie the symptoms being displayed at home and school. Although a number of therapeutic issues may exist and be worked through at different stages in the play therapy process, in the majority of cases, children first work on issues related to emotional self-expression. In the case of children whose problems center on problems with opposition, defiance, and conduct, sessions often focus on expression of anger/rage and the desires to control and dominate others. For children whose problems center on perfectionism, anxiety, or depression, sessions focus on developing greater emotional flexibility and self-assertion. Regardless of the central problem, the "aggressive" stage of the play therapy process ultimately results in the child developing increased

emotional intelligence, greater confidence in self-expression, increased gains in self-control, and the development of more responsible and adaptive ways of interacting with others.

As with all the stages, the behaviors of a given child can be quite unique. However, some frequently encountered behaviors include aggressive acts toward the bop-bag, stuffed animals, puppets, etc.; aggressive role plays with puppets; "trashing" the playroom; "pretend" interpersonal aggression toward the therapist either in roleplay (pretends to shoot the therapist who is in the role of a robber) or in a direct manner (pretends to stab therapist as therapist); and verbal aggression against the therapist through insults and name calling. Control issues generally emerge in such behaviors as directly telling the therapist what to do, taking authoritarian roles in role plays, and breaking playroom limits.

In general, in the "aggressive" stage children tend to engage in active, high energy, gross motor play and/or assertive verbalization. However, it should be noted that in some cases it is the child's baseline behavior and not an absolute one which is most useful in identifying "aggressive" stage play. For example, a conduct disordered five-year-old boy may use profanity toward the therapist, frequently break limits, unceasingly clobber the bop-bag, throw everything on a table onto the ground, and refuse to leave the playroom at the end of a session. On the other hand, a shy, overanxious, perfectionistic five-year-old girl may "accidentally" pour water on the floor, have minor arguments/skirmishes with an animal family, make frequent requests that the therapist get things for her, and plead in a whining voice for more play time once the session is over.

As was indicated previously, the duration of the "aggressive" stage of the play therapy process varies from child to child. Children whose primary problems center on opposition, defiance, and conduct problems may remain for an extended time in the "aggressive" stage as they work through control, anger, rage, and grief issues. Other children may have relatively short periods of "aggressive" stage play since their central issues may be more easily worked on in the "regressive" stage.

The "Regressive" Stage

Following the "aggressive" stage most children begin to display behaviors which collectively we have labeled the "regressive" stage. In this "regressive" stage of the play therapy process children work on issues related to nurturance, attachment, dependence/ independence, identity and self-image, and other issues related to relationships with others. Children display a wide variety of behaviors in the "regressive" stage. Some children focus on nurturance behaviors such as cooking meals, giving a tea party, telling a bedtime story,

and role plays involving "doctoring." The child may be the provider or recipient of such nurturance or alternate such roles with the therapist. Other children may focus more on working through threats to attachment by engaging in role plays involving protection and rescuing behaviors; sometimes such children will literally "bind" the therapist or other symbolic representations of significant others to themselves in role plays by using a piece of rope or by imprisoning the therapist and/or themselves. Other children will focus on resolving dependency issues with pleading requests for help from the therapist to assist them with a variety of tasks that, in reality, they could do for themselves.

In the "regressive" stage, children may also engage in some forms of age regression. This age regression may be evident in their verbal communication either in voice tone, vocabulary chosen, or pronunciation of words. Age regression may also be evident in overt behavior, taking a wide variety of forms such as pretending to be a young child; putting a bottle or pacifier in the mouth, cuddling up in a blanket, "taking a nap" while verbalizing in the role of an infant, engaging in babbling/baby talk, or even crawling around like a baby. It should be noted that these more pronounced "age-regressed" behaviors such as crawling around and engaging in almost pure "baby talk" are present in only a small percentage of children's play, however, some less dramatic forms of age regression are commonplace in the "regressive" stage.

The "Mastery" Stage

Following the "regressive" stage, children next move into the "mastery" stage. For many of these children the "mastery" stage is a time of strengthening and consolidating therapeutic gains. Children often spend time in either solitary or interactive role play and/or creative and competency based solitary play. Through such play children demonstrate competence, the ability to master past difficult situations, and the ability to exert leadership and self-control. Role plays in which they had engaged in the past now have more positive and adaptive outcomes compared to those in the "aggressive" and "regressive" stages.

Other children may not engage in role play at all. Instead they may display their creativity through artwork, creation of their own games, and construction projects with blocks. In drawings or paintings, the themes of their artistic creations are generally either neutral or positive, perhaps in striking comparison to the negative affect and dysphoric quality which may have been evident in earlier productions. Other children engage in solitary or cooperative play which demonstrates their ability to successfully accept challenges, stay focused in the face of adversity and frustration, and accept both victory and defeat. Such children may engage in truly difficult tasks, projects, and

challenging activities such as balancing a tower of blocks, competing head-to-head with the therapist in a "nerf" basketball game, or trying the ring toss from a far distance. What is different from other stages is that they attempt more challenging things alone, and react appropriately to success and failure.

Finally, it is necessary to point out that for some children the "mastery" stage is devoid of additional therapeutic work and projective material. These children have simply completed their therapeutic work and, therefore, engage in relatively mundane and normal childhood activities with or without the therapist. For example, a given child may have engaged in remarkably active, theme-oriented, and psychologically rich interactive and solitary role plays in the preceding stages, but now just comes to sessions and plays cards with the therapist in an everyday manner. It is as if these children have run out of "psychological juice." Such children have completed their psychological work and sometimes engage in exploratory and unfocused switching from one activity to the other much like many children who are in the "warm-up" stage. These children may still deeply value their relationship with the therapist and enjoy coming to sessions; others may enjoy their visit with the therapist, but express being bored or desiring to leave sessions early. Their need for psychological exploration and resolution has been met, at least at this period of their development.

It should be noted that as children enter into and continue working through issues during the mastery stage, they may revisit certain issues briefly throughout the remainder of their sessions. In such "mastery" stage sessions children may exhibit "aggressive" or "regressive" behaviors. It is our view that these brief revisits do not represent a move backward into an earlier stage but are rather putting on the finishing touches in resolving previous therapeutic issues.

Transitional Stages

For pedagogical reasons, the previous sections have described the four stages of the therapeutic process as if they were pure and completely differentiated from each other. Here we wish to note that not only do the stages vary in duration from child to child, but indeed it is more the rule rather than the exception that stages blend with each other in a given session. For example, although there may be a few "pure" sessions of "aggressive" stage play, it is usual that sessions would eventually display a blend of "aggressive" stage and "regressive" stage play as aggressive stage issues are worked through and regressive stage issues begin to emerge as new issues to be worked on. As long as the preponderance of a given session is characterized by "aggressive" stage play we would still consider the child to be in the "aggressive" stage.

However, if the child's behaviors in a given session contain approximately equal amounts of "aggressive" stage and "regressive" stage play we would label it a "transitional" stage.

The introduction of "transitional" stages adds both complexity, as well as a more realistic approach to understanding the therapeutic process in Child-Centered play therapy. However, of the additional complexity, there still remains considerable consistency with regard to the general progression which is observed across sessions: pure "aggressive" stage play; mostly "aggressive" stage play with some "regressive" stage play; equal "aggressive" and "regressive" stage play (a transitional stage); some "aggressive" stage play but mostly "regressive" stage play; pure "regressive" stage play; mostly "regressive" stage play with some "mastery" stage play; equal "regressive" stage and "mastery" stage play (a transitional stage); and pure mastery play.

Implications of the "Stage" Model

Most of the focus of this article has been on providing descriptions of the stages of the Child-Centered play therapy process. Emphasis has been placed on providing descriptions of behaviors, themes and therapeutic issues associated with each stage. It is our hope that this "stage" model will help play therapists develop clearer insight into the Child-Centered play therapy process, and ultimately assist clinicians by making the complexity of play sessions more understandable. Such an understanding should enable the therapist to track movement and progress across play sessions, and facilitate decisions regarding termination of sessions.

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“*If we wish to understand our
child, we need to understand
his play.*”

—BRUNO BETTELHEIM

Client-centered Play Therapy Techniques for Elementary School Counselors: Building the Supportive Relationship

Emily Phillips

Jodi Mullen

This article examines the application of nondirective child-centered play therapy to the work of the elementary school counselor. School counselors are in a unique position to create supportive and therapeutic relationships with children experiencing stress. Factors to consider when deciding whether to use play therapy techniques are offered including: selection of children and materials, location, and support needed. Case vignettes are supplied to provide insight into how play can be incorporated into school counseling.

Introduction

The elementary school counselor has a formidable job. The roles of teacher, mentor, consultant, coordinator, and clinician all press upon the counselor for attention. Within the clinical realm, increasing numbers of children are being referred for individual counseling. Counseling children can be a challenge, because children are often less verbal, less insightful, and less able to clearly identify and express feelings.

In order to meet this challenge, many school counselors use forms of play as a vehicle to either distract a child who may appear anxious about talking with an adult, or to form a bond with a child through a familiar medium. Although these are play techniques, they do not constitute play therapy.

"One of the common misconceptions about play therapy that is sometimes heard from school counselors and school psychologists is that play is a way of distracting children in order to facilitate talking. Using play in this manner

is not play therapy, but simply a technique of talking therapy" (Cerio, 1994, p. 74). Play therapy as a therapeutic technique is different from simple play.

This article will look at what makes play therapy different from simple play and how the use of nondirective child-centered play therapy can assist the elementary school counselor with counseling services which attempt to match the child's developmental level. There are several different approaches to play therapy. According to Cerio (1994), "Each approach represents different conceptual templates and different techniques that are used within the broader framework of play therapy. Play is the medium, not the message" (p. 73). This article will focus attention on client-centered, nondirective play therapy techniques.

What is consistent among the forms of play therapy is a basic belief that humans have the potential for self-healing. "Individuals have within themselves vast resources for self-understanding and for altering their self-concepts, behavior, and attitudes toward others" (Corsini, 1989, p. 189). Counselors can tap this reservoir for self-healing through play therapy.

Play Therapy's Place in the School

The world is changing at a rapid pace. Society expects the schools to take on more and more of the tasks usually reserved for the family (Miller, 1989, p. 77). School counselors are being encouraged to use a developmental model and developmentally appropriate techniques and interventions. Play therapy has gained in popularity as an excellent resource to reach this goal.

The elementary school counselor is in a position to assist children in their development. Landreth (1987), a noted expert on play therapy states, "It seems, then, that it is not a question of whether the elementary school counselor should use play therapy but, instead, of how play therapy should be used in the elementary schools" (p. 255).

The number one objective of school counselors is to assist children in becoming successful learners. Although concerned about personal and family issues as well, most elementary counselors, having large caseloads and, often servicing more than one building, feel pressure to prioritize services according to those behaviors which interfere with successful learning. "Play therapy also assists in accomplishing the broader school objective of learning about the world by helping children get ready to profit from the learning experiences provided by teachers" (Landreth, 1987, 257). Children may sometimes bring the burdens from their lives outside of school into the classroom.

While teachers are excellent at identifying children who might be experiencing a life stress which is interfering with the child's learning, they do not

have the training or time to focus undivided attention on one child on an ongoing basis. Referral to the school counselor can provide space and time for the working through of the child's life issues. The attention from the counselor can often improve classroom performance by providing a regular and safe place in which the child can express tensions and feelings (O'Connor, 1991). Play therapy is a developmentally appropriate mechanism for providing counseling services. "Play therapy is an adjunct to the learning environment, an experience that helps children gain maximum opportunities to learn" (Landreth, 1987, p. 257).

Elementary school counselors have numerous opportunities to interact with children and become aware of their difficulties. They also have training in child development, allowing them to assess the developmental level of children and provide a safe, secure environment in which the child can share and grow.

Why Play Therapy is Important

For children, play is the medium for communication. Children live through play; they express the phenomenology of their existence, giving a view of what their experiences are like. "Play therapy is based upon the fact that play is the child's natural medium of self expression. It is an opportunity which is given to the child to 'play out' his feelings and problems just as, in certain types of adult therapy, an individual 'talks out' his difficulties" (Axline, 1947, p. 9). Children use play as their language; toys become their means of communicating.

Play has several purposes. One use of play is to allow children to show their experience of life and pain when there is enough security and freedom for them to move at their own pace. "One purpose of a play session is to create a situation in which the child may become aware of the feelings he (sic) has not allowed himself to recognize" (Guerney, 1979, p. 219). Sometimes parents, having their own issues and concerns, have not provided a safe enough environment for the expression of feelings. A child may be keenly sensitive to a parent's mood or worries and may not feel comfortable expressing feelings which might further upset a parent. This is not at all uncommon following a separation or divorce where a child might feel that discussion of intense feelings might cause increased parental distress. Another purpose of play therapy is to serve as a rehearsal for life, with children acting out roles and situations which can form their fundamental orientation to the adult world (Axline, 1947).

Theoretical Basis

Play therapy is used by counselors with a variety of theoretical orientations. Among the approaches to play therapy are those which are highly structured, such as those used in hospitals for pre-operative counseling and those used for sexual abuse investigations and treatment (Boyd-Webb, 1991). Some forms strive to bring the child back to earlier stages of development and assist with the child's movement through those stages again (Walder, 1979). Still others use a model to discover inappropriate behavioral patterns and then alter them (O'Connor, 1991).

Some play therapists train parents in play techniques as both a follow up to play therapy and a method to improve parent-child relationships (Guerney, 1964). Some forms are activity based, often used with older children to allow projects to be used as a vehicle for treatment (Semonsky & Zicht, 1979).

One of the most important considerations for counselors is not the theory on which to base treatment but the match between the counselor's beliefs and the child's needs. The counselor-client relationship is crucial. Landreth (1991) describes this relationship as one of mutual acceptance and appreciation by stating that:

Respect for the person of the child and the prizing of the child's world are not activities of the mind. They are genuinely felt and experienced in the inner person of the therapist and sensed and felt by the child, who deeply appreciates and values the therapist for such unconditional acceptance. This relationship with the child in the playroom, then, is a mutually shared relationship of acceptance and appreciation in which each person is regarded as an individual. (p. 74)

The form of play therapy we will be examining is based on the work of Virginia Axline (1947) and is comparatively unstructured and relationship oriented. The counselor using child-centered play techniques places the greatest emphasis upon the relationship. The relationship between the counselor and the child is the most important construct of treatment. The goal is to view the world through the child's eyes. "By bending all your efforts toward trying to put yourself in the child's place and understand the world as he sees it, not as you see it or wish him to see it" (Guerney, 1979, p. 223). Following is a brief summary of Axline's child centered model. The major themes of this model will be integrated into brief vignettes which demonstrate the use of play therapy with elementary children.

Nondirective, Child Centered Model

Axline's (1947) model of play therapy is based upon eight basic principles.

1. Mutual respect. Efforts are made to provide the message that the child is okay as he/she is. Technique revolves around efforts to discover what the child needs from treatment.

2. There is no agenda. Permission is given for the child to do whatever is needed, within established limits. The child is accepted for where he/she is currently, not where the counselor would like him/her to be.

3. No coaching, criticizing or judging is done. Children are not encouraged to use certain toys or discuss topics of interest to the counselor.

4. Play is an expression of the child's world, and the counselor's goal is to gain a clearer understanding from the child's perspective.

5. The child is the decision maker in play. The counselor does not set the goals but, instead, follows the child's leads as they occur.

6. Stick with the child's agendas. Children will often cycle through themes which are the most salient to them until they have mastered or abandoned them.

7. Every behavior is purposeful; be patient and tolerant and themes will emerge.

8. Anger can be managed productively. Redirection of the child's anger provides an experience which is reality-based. The child is given the responsibility of choice in how to express his/her anger and the consequences which may ensue. (pp. 73-74)

Factors To Consider

Clientele

Play therapy techniques can be used with a wide variety of children. Client-centered play therapy works well with the acting out child, the withdrawn child, and the anxious/stressed child. Children whose histories include parental alcoholism or drug abuse, post death trauma, physical or sexual abuse, stress of transitional families, separation anxiety, attention deficit/hyperactivity disorder, bullying or being victimized are all appropriate candidates for play therapy. Play therapy has been used successfully with children lacking in verbal ability and articulation of affect and those with disabilities (Axline, 1979). Therefore, there appears to be few restrictions regarding the clients with whom play therapy may be used.

Support

To assist with appropriate referrals and help assure administrative support, efforts to orient teachers and other staff to the goals and potential outcomes of play therapy are essential. Few teachers have had experience with or exposure to play therapy. In order to maximize smooth operation and results, teacher orientation towards play therapy is beneficial (Landreth, 1987, p. 260).

Location

There are a number of factors to be considered when deciding to use play therapy techniques. The availability of a separate space or room set up for play, the size of the room and proximity to a sink can influence the counselor's selection of toys and use of limits. The counselor's personal preferences regarding mess and noise are also factors. "The idea is to make this a place very different from the classroom, a place to curl up in a beanbag or to pound on clay, a place to be yourself" (Fall, 1994, p. 74).

The proximity to other classes/offices will affect tolerance for noise. Even if the counselor feels comfortable tolerating loud activity, other staff nearby may not be as tolerant. This is understandable, as most counselor offices are located either in a central office suite or near a classroom. Supplies on hand and budget allocations can have an effect on number and variety of toys in the counselor's play room.

The necessity of maintaining an office which functions as more than a play room can also be a limit. The size of the room is not essential, but space which allows for privacy and confidentiality is. In addition, the integrity of expensive equipment and important files and supplies may need to be maintained. Perhaps a small closet, in an out of the way spot in the school, can be set up if the school counselor's office is within the office suite.

A large number of toys is not essential although consistency of supplies and available toys provides stability and comfort for children who may not be receiving this at home. According to Landreth (1987), "Because toys are the child's words, they should be in good condition. Broken toys interfere with the child's play language and should be removed" (p. 257).

Setting Limits

Although child-centered play therapy is nondirective, limits are set. Limits help by providing essential structure and helping the child understand that in real life there are rules. Rules are necessary to ensure physical safety of

counselor and child, and to keep the professional office intact (Axline, 1947; Landreth, 1991).

Rules in play therapy can both limit danger and allow permissiveness by giving the child choices. For example, a play therapist may decide that a child who has an overcontrolling parent may need to experience freedom from some parental messages, such as "don't get dirty; don't be rough on the toys, put back whatever you use right away." In this situation, the counselor may choose to set limits that do not restrict the child but rather allow him/her to experience more personal freedom and less anxiety.

Children often challenge limits. A clear plan needs to be in place to deal with these situations. Guerney (1979) suggests, "If the child should 'break a limit,' you should point out that this particular behavior is not allowed. If this statement does not suffice and the behavior occurs a second time, warn the child that the play session will end if it occurs a third time" (p. 224). For most play therapists, the consequence for the child's breaking the set limits is to have the session end (Bixler, 1979).

Limits are not set, however, on what the child says and feels. "There should be no limits on what the child says, including swearing, dirty words, hostile comments toward the parent, or others" (Guerney, 1979, p. 224). Realistically, within the school setting, this allowance may need to be tempered by proximity of the counselor's office to others, noise barriers in place, and the need of the child to return calmly to the classroom following a session. Accommodations can be made by having the child whisper or write the swear word, meeting both the child's need for expression and the counselor's need to be sensitive to the outer environment.

Recommended Supplies

Toy selection rests on the concept that toys become metaphors for real life situations and conflicts the child may be experiencing. Real life toys such as dolls, houses, family figures, baby bottles, medical kits, cars, and phones are necessary (Cerio, 1994; Landreth, 1987). The variety of toys is more important than the number of toys (Cerio, 1994).

Many of these toys can be purchased inexpensively by frequenting garage sales and by placing notices in teachers' mailboxes or in newsletters sent to parents. A drop box for toys that teachers and parents no longer want can be established in the main office, with the counselor responsible for delivery to a local social service agency. Coordinating this toy drive gives the counselor the opportunity to have first pick of these toys. Guerney (1979) reminds us that, "Primarily, the toys should be plastic, inexpensive or unbreakable" (p. 221).

Intentionality

As children are referred to the counselor the process of case conceptualization occurs. The child's background is reviewed to provide insights and hypotheses regarding factors influencing the child's behavior and the treatment approach that might be most successful. The decision to use play therapy techniques is made from this assessment.

Case Vignettes

Following are several cases from our own personal experiences where child-centered play therapy techniques have been used. A brief excerpt of how play was incorporated into counseling has been provided. These examples illustrate how play and counseling can interact to support one another.

Vignette One

A second grade boy has been referred with behaviors consistent with Attention-Deficit Hyperactivity Disorder. He cannot take medication due to a congenital heart defect. He has no friends. Anger is the chief emotion expressed, especially toward other children who shun him for being "too wild." The teacher reports that he is often rejected by others, and angry reactions towards him are commonplace.

John selects troll figurines during this his fourth visit. He sits at a round table, making the trolls fight. He growls and makes biting noises.

CO: You're growling and biting.

JOHN: I'm gonna bite their heads off (proceeds to put two in his mouth and rip out their hair with his teeth). That'll teach them to not let me play.

CO: They won't let you play.

JOHN: They never let me play. (crying) I can be good; I can be good.

CO: You'd like to play with friends and want to be good.

JOHN: Yeah, (smoothing the hair that's left on the two trolls) I don't always remember how to be good.

Clinical commentary. John is able to experience himself as being okay, resulting from mutual respect. He is being provided with a safe place in which he can express his feelings and learn about limits.

Vignette Two

A kindergarten girl has been referred several months into the school year. The teacher describes her as shy and withdrawn. She keeps to herself both in class and on the playground. She cries and becomes anxious during class activities such as cutting, gluing, and paper mache. The teacher describes the mother as a "fuss-budget" who has warned this child about getting dirty or messy.

Sally chooses colored paper and begins a picture of flowers. She darts her eyes up at the counselor, while drawing the flowers with a pencil before coloring them in. She chooses four crayons - pink, green, gold and silver. While coloring in one of the flowers with the gold crayon, it breaks.

SALLY: (crying) Oh no, now you're mad. I'm in big trouble.

CO: You think I'm mad because the crayon broke.

SALLY: I'm bad; I'm bad. You're mad. (wrings her hands - stands up to leave the room). I better go.

CO: You think you're in big trouble because the crayon broke and you're scared.

SALLY: I ruined the picture; I ruined the crayon.

CO: Sometimes it's hard to be a kid and make mistakes.

SALLY: Yeah. Now we have two gold ones.

CO: You solved the problem.

SALLY: (small smile) Oh? (picks up the silver one and snaps it) There, now you have two silver ones too (cringes).

CO: Now I have two gold and two silver ones. You wanted to make sure I really wouldn't get mad.

Clinical commentary. Sally is able to reduce her own anxiety as the counselor accepts her exactly as she is. She feels free to express her feelings completely. The child is given permission to test the limits and make choices in a safe environment.

Vignette Three

A fifth grade girl who is bossy to other children has been referred. This bossiness is worse during less structured times, such as gym and class games. She hates to lose any game. She is a bright child with high expectations of herself and others. She is self-centered and has little empathy for others. She

thinks most other children are too slow, and too stupid to do things right and often expresses this to the other children who avoid interacting with her.

Marla selects two foam paddles and hands one to the counselor. She drags a chair up in front of the counselor and whacks at the air in front of the counselor's chest.

MARLA: I could hit you if I wanted.

CO: You want me to know just how strong and powerful you are, but one thing you cannot do is hit me even with the paddle. You can hit the floor or the wall.

MARLA: I could hurt you.

CO: You're feeling strong enough to hurt me.

MARLA: I'm stronger than everyone in my class. I could do this (comes really close to the counselor's knee with the paddle, but does not hit her).

CO: You are showing me that you want some control.

MARLA: You're afraid of me.

CO: You want me to be afraid of you.

MARLA: Everyone else is. That's why they won't hang with me at recess.

CO: You want me to be scared of you.

MARLA: That's right. I want you to sit there and take it like my mom does.

CO: You've seen mom hurt a lot.

Clinical commentary. The counselor is able to accept the complete child, aggressive as she may be. This respect enables Marla to feel safe enough to share an important family secret.

Summary

By providing what the child needs and by giving permission for play directed by the child, a powerful environment for healing is produced. The particular play medium used is not important; all can benefit the child. Corsini (1989) reminds us of the power of imagination and play when he commented:

The potential for healing associated with creativity, spontaneity, physical action, excitement, mutuality, imagination, playfulness, flexibility, self-expression, and a willingness to expand one's vitality by including the powerful channels of poetry, dance, song, music, drama and art. These rich resources for

vitality represent innate connections to the best part of childhood and are filled with pleasure....They enhance personal autonomy, identity, effectiveness and hopefulness. (p. 562)

Providing hope is one of the best services a school counselor can offer. The profound effects which play therapy can have are best articulated by a 6 year old girl who said, at her last session with one of the authors, "Feel my muscle. See, I'm getting stronger on the outside and the inside."

The profound positive effect of the relationship for growth and change is at the basis of almost every major theoretical counseling orientation. This is true of play therapy as well. The school counselor is in a position to establish a long-term primary relationship with a child. Elementary counselors are integrated in the day-to-day school experience, serving as stabilizers during times of stress, and being able to monitor children over the course of several years. Play therapy techniques are a viable option to add to the school counselor's repertoire when designing interventions for children in need. Nondirective, client-centered play therapy is one of several approaches which can be used to incorporate play as a therapeutic technique in the school setting.

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Developmental Considerations in Play and Play Therapy with Traumatized Children

Athena A. Drewes

Child and play therapists need not only to have knowledge of the pathological behaviors of children, but also of normal development. Particular behaviors may be thought to indicate abuse, with the therapist ignoring the possibility that the behaviors reflect age appropriate development. This article focuses on various parameters that play therapists working with traumatized children come across in working with children: play stages and behaviors, the impact of trauma on development, differences in play styles, and special considerations of aggression, language and communication, and sexual behaviors in traumatized and non-traumatized children. Several case examples from the author's experiences are given along with play therapy techniques, which may be helpful in working with the traumatized child.

When treating children who may have experienced some form of trauma, both experienced and beginning play therapists must consider developmental aspects of children's play and presentation of problems. Knowledge of developmental aspects will help in differentiating normal from maladjusted behaviors. Therapists working with specialized populations in outpatient or residential settings can at times become complacent in assuming that all presenting problems indeed reflect trauma. We may at times overlook or magnify behaviors, which may in fact be normal for the child's age and cognitive or emotional stage. This may be especially true in trying to assess whether sexual behaviors and play reflect normal development or some form of trauma. Play therapy can be an extremely powerful modality, but it is also a complex, subtle and sophisticated tool. The play therapist needs an in-depth understanding of how children think, interact, communicate and change –

both normally and when traumatized (Donovan & McIntyre, 1990). It is important to consider the developmental levels of the child when considering what types of techniques to utilize, what treatment areas will need to wait until later development has occurred, and how best to assess whether there has been progress in treatment. The therapist needs to think not just of symptom reduction when treating a child, but also of improvements in developmental progression. "In direct treatment of the child or in therapeutic work with the child...our objective is to bring the child up to the level of development appropriate for his age...This means, further, that a theoretical knowledge of the psychosexual development of children, and the developmental tasks and conflicts which come with each stage, are an indispensable part of the worker's equipment" (Fraiberg, 1951, p. 179). Mordock (1993) also has written that therapists need to evaluate whether the child has reached developmental levels adequate for the child's age, assess the degree to which the child lags behind, and determine whether regression or arrest is responsible for the developmental imbalance. He also states that by pinpointing and describing the traumatized child's developmental imbalances a greater understanding of the child's difficulties is obtained over merely characterizing the child by symptomatology. Thus, he concludes, symptom reduction, in traumatized children, is not an adequate criterion of therapeutic growth. Rather the standard of measure should be the child's developmental advancement as compared to developmental mastery for the child's age group.

Trauma can impact on any and all levels of the child's development, including intellectual development, physical health, emotional functioning and social skills. The development of attachment to caregivers, the way the child regulates affect, the child's sense of self, and differentiation, and the use of symbolic and representational thought, as well as peer relations and adaptive school functioning, are all affected. Finally, trauma can have different or additional meanings as a child develops. These components may result in significant impact on the child's development and require a return to therapy at a later date. Consequently, child therapists need to also consider a developmentally sequenced approach to treatment (James, 1989).

This article will outline three developmental play stages as formulated by Piaget, which are based on his theory of cognitive development. The discussion will also outline differences in play styles, and special areas of consideration such as, aggression, language and communication, and sexual behaviors as contrasted between traumatized and non-traumatized children. Case examples with play therapy techniques, drawn from the author's play therapy experiences, will allow child therapists to consider ways of conceptualizing their cases along developmental lines.

The work of Piaget (1962) has been used to understand play dynamically. He viewed the development of human intellect as involving two related

processes: assimilation and accommodation. In the process of assimilation, individuals abstract information into the organizing schemes representing what they already know. They also modify these organizing schemes when they do not fit adequately with their developing knowledge, which is called accommodation. Play, according to Piaget (1962), is a way of abstracting elements from the outside world and manipulating them so they fit the person's organizational schema. As such, play serves a vital function in the child's developing intellect (Bergen, 1988, p. 14).

Piaget's stages of play

Piaget (1962) offers a model of development of play behavior in normal children. He defined three distinct stages in the development of play: sensorimotor play, symbolic play or pretend play, and games that have rules.

Stage One: Sensorimotor stage

Non-traumatized Children

Sensorimotor play begins at birth and continues through 18 to 24 months, coinciding with the sensorimotor stage. In the sensorimotor stage language and symbolic function are absent. The child progresses in a logical order from reflexes through habits, into imitation. Then, the child is able to wait before immediately imitating another's action. The primary function at this stage is the assimilation of sensory information into the cognitive processes. Movements more than stationary objects attract the child more readily. Play evolves during this stage from a purely reflexive behavior of grasping objects and orienting toward sound and visual stimuli to displaying interest in oneself or interest and conscious control of objects in the external world (Schaefer & O'Connor, 1983). Sensorimotor play is "repetition with deliberate complication" (Rubin, Fein, & Vandenberg, 1983, p. 700), in which adaptive behaviors are consolidated and reorganized. Piaget called sensorimotor play, practice play because of its repetitive nature (Bergen, 1988, p. 50).

During the sensorimotor stage the child forms object permanence and object constancy. That is, they are able to hold mental representations of people, themselves, and others, a kind of memory system, going from "out of sight, out of mind" to seeking out the missing item (Piaget, 1962). The child comes to know the world on a primitive level (Schaefer & O'Connor, 1983).

By 8-12 months the purpose of play is often to have fun, seek out novel situations, and explore them with interest. Spontaneous play in children is essentially a means of investigation and experimentation with the laws of nature and human relationships (Haworth, 1964). The sensory-tactile contact

with the world is important. Non-traumatized children continuously test out a new environment to satisfy their curiosity. They, in turn, are able to gain familiarity with their surroundings which contributes to their sense of security. Non-traumatized children will move and discover their body in relation to the space around them. They will test out their energies.

Traumatized Children

In contrast, traumatized children are inhibited in the flexibility, fluidity and spontaneity typically seen in children during these younger years (Haworth, 1964). With normal development the child's positive experiences, perceptions and objects associated with those perceptions, are assimilated in a positive way and the child then develops trust. When this has not been a positive period, then the child is not likely to develop an adequate sense of trust, and in turn, the child may find the ability to assimilate additional stimuli and experiences inhibited (Schaefer & O'Connor, 1983, p. 75).

Strong attachment in infancy has been related to later competencies such as empathy, sympathy, problem solving, ego resiliency, high fantasy predisposition, play skills and sociability (Curry & Bergen, 1988, pp. 110-111). Children who have suffered from a rejecting or inadequate environment in very early life may grow up with impaired development in self-esteem, unable to experience themselves or the world except as ugly, harsh, cold, painful and unsafe (Gil, 1991). In later years, they may become needy, demanding, whiny and constantly searching for support. As a result, transitions are difficult with the child unable to let go, or trust that they will get what they need later when the parent or adult is available. The child may become aggressive and act out, fearing close attachments, which may result in loss. Consequently, they may push people away, distance themselves through withdrawal, have greater difficulty with unfamiliar peer groups and may try to boss and control others. (James, 1989).

Play Therapy Techniques

The technique of Theraplay is useful with older children who may have incurred trauma or poor mother-child attachment in the sensorimotor stage. Theraplay focuses on the level of sensorimotor play, helping the child to form a relationship with a safe adult. Theraplay was developed "to replicate the joyful and adoring features of the parent-infant interaction" (Jernberg, 1983, p. 136). Nurturing activities, imitative of positive parent-infant contact during infancy, may include gentle rocking, soft stroking, lullabies sung, or the child's back being powdered or hand lotion applied to the hand and arm, and hair combing. Theraplay is conducted by the therapist who also engages the parenting figure in the techniques for carry-over with the child at home, and

in building an emotional attachment. The activities allow for a recreation of this early stage whereby the child can move developmentally forward past the emotional block and come to trust others and the world.

Stage Two: Symbolic or pretend play (pre-operational stage)

Non-traumatized Children

Piaget's (1962) second stage is based on the child's development of symbolic or pretend play. This is the primary type of play behavior observed in children between 2 and 6 years. This stage coincides with the pre-operational stage of Piaget whereby the child deals with the world in a more realistic way. Curiosity and excitement are dominant at this stage. Although vocabulary development is rapidly growing, a child still has limited verbal skills during this stage. Thinking tends to be more accessible through non-verbal than verbal means. Thoughts are intuitive, imaginative, and characterized by "magical thinking," and unrestrained by adult logical rules. The child begins to have symbolic representation and engages in fantasy activities. For children this age, the world is an alluring place to explore. They want to touch, smell, hear, test things out, and learn through action. They may prefer not to sit and tend to be noisy, having a great deal to say. Their point of reference will be very personal and egocentric, as they want to initiate actions by themselves. Children move from projecting their own wishes and impulses onto the environment. For instance, if a child wants more candy, he or she will state that a stuffed animal wants more candy. Children will also use their own bodies symbolically (e.g., pretending to be a lion or tree). Later they are able to reproduce both real and fantasized events through dramatic play (Schaefer & O'Connor, 1983). The crucial development in this stage (Nicolich, 1977) is the ability to assume the "as if" position, assimilating enough stimuli and organizing them into perceptions of objects which are consistent enough to allow children to act as if objects are present when they are not. Later on, actions may be internalized in association with objects, and children can anticipate the consequences of their actions (Schaefer & O'Connor, 1983).

In the second stage, well-functioning children make great strides toward autonomy. They are able to show pleasure in solving a task, and remain involved in the face of frustration while examining alternative strategies before giving up efforts in solving the problem (Farber & Egeland, 1987). The preschooler develops self-regulation, impulse control, self-awareness, identity formation, and peer relations. The issue of control (both by the parent and self-control) is particularly critical at this developmental stage. Arrests in this area due to trauma can have extreme consequences in later years (Curry & Bergen, 1988, p. 116).

Gould (1972) points out that children's roles during this stage display primary identification with the nurturant/provider, the aggressor, or the victim. Consistently positive experiences with nurturance result in children's predominant identification with the provider and is evident in their role-play, even those roles with highly aggressive content (e.g. Superman, policeman, doctor) are played with a strongly nurturant, rescuing aspect.

Traumatized Children

Children who have had primarily negative experiences in nurturance portray a prominent identification with either the aggressor or victim, and manifest a rigidity in this defensive depiction of victim or aggressor representations (Gould, 1972, p. 266). Such children are unable to take distance from themselves in play and tend to become the role, with difficulty distinguishing reality and fantasy. They may also have difficulty engaging successfully in play due to a reluctance and limitation in using symbolic play. In addition, motivation to become engaged may come only from extrinsic rewards and requests, and expectations and demands of the authority figures may often generate frustration and anger. Consequently, disappointment and failed expectations due to undeveloped problem-solving skills, poor abstract cognitive thinking skills, inability to control impulses and emotions, and poor social skill development can result in limited involvement by the child (Curry & Bergen, 1988). New skills and tasks challenge the child's sense of self, and failures associated with new tasks pose a threat. The child feels insecure and untrusting of their own ability and anticipates failure (James, 1989).

A child with impaired abilities to engage in pretend play is at a disadvantage. Pretend play is often assumed to have a strong communication function and therefore is an integral part of the more analytically oriented therapies (Schaefer & O'Connor, 1983).

Play Therapy Techniques

In order to help stimulate pretend play, the therapist can utilize the Sandplay or Sandtray technique whereby the child creates a "picture" in the sand using miniature toys, figures, animals, and materials (Lowenfeld, 1970). Through the Sandplay experience and the therapist's understanding of the symbolic meanings of the miniatures selected and arranged, a healing and integrative process occurs for the child. Hand puppets, staged dramas, and charades also help to stimulate the child's fantasies.

Stage Three. Games and rules (concrete operational stage)

Non-traumatized Children

Piaget's final stage of play development deals with the child's participation in games with rules (Piaget, 1962). This stage begins around age six and coincides with the concrete operational stage where the child thinks more concretely and less intuitively than during the previous stage. The child becomes more rational and more concerned with categories of objects. They are still tied to the "here and now", unable to transcend the concrete and consider different possibilities. Although they can begin to plan ahead, they will often tackle a problem. Their approach can be practical, based on empirical evidence (Phillips, 1969). During the earlier part of this stage the child enjoys the process of playing, and an interest in cooperative games, and eventually competitive games evolves, especially as they enter adolescence. This stage has a strong interpersonal or social component whereby the child learns to cope with constant interpersonal contact (Schaefer & O'Connor, 1983). While most authors agree with Piaget's delineation of games-with-rules as typifying the play of school-age children, pretend play does continue (Curry & Bergen, 1988). The child is able to use dramatic play to test out many fearful fantasies under the safe guise of play. They can take distance from their frightening fantasies and feel more in control by attempted mastery through staged dramas, written plays as well as dramatic play (Arnaud, 1971, p.11).

In addition, the child moves from the intrapersonal into the interpersonal level, having to deal more with social contact and group structure. If the child has established secure relationships with others, the child will have the capacity to explore the environment effectively and develop a cooperative relationship with non-family members (Bergen, 1988).

Traumatized Children

With impairment in this third play stage, the child's ability to play cooperatively with peers and tolerate losing is handicapped. The feelings aroused by the group situation in peer relationships may serve to escalate the child's emotional state to an uncontrollable level. Competition with rivals for attention and approval may also disrupt the sense of cooperation and group cohesion necessary for a stable learning environment. The child may push to maintain a hostile, critical involvement with others (Schaefer & O'Connor, 1983).

Play Therapy Techniques

There are numerous therapeutic board games available, such as "The Talking, Feeling and Doing Game" by Richard Gardner, that help elicit thematic and emotional material from children. However, the therapist can also be creative in utilizing games such as "Checkers" and "Sorry" for diagnostic purposes and to help elicit emotional material (Nickerson & O'Laughlin, 1983). For example, in Checkers the child has to answer a question or talk about emotional issues and problems each time they take a checker in a jump, or in "Sorry" whenever they "bump" a piece when a "Sorry" card comes up.

Impact of Trauma on Development

In normal development, the child's capacity for play will progress through developmental stages with little guidance. It is the child who has suffered a trauma, on an acute or chronic level, who can have trouble negotiating through the developmental levels and may become "stuck" at one stage or may regress to earlier infantile levels. When a child has been traumatized by events such as fire, death, divorce of parents, or by abuse, their development becomes uneven or injured over many areas of functioning. The different systems (e.g., psychological functioning, physiological, cognitive, social skills and abilities) are interrelated, with advances and lags in one system affecting another (Farber & Egeland, 1987). Given that trauma can cause an arrest in the child's developmental growth process, the goal of therapy is to revive this process in an accelerated form (Haworth, 1964). The development of affect regulation and differentiation, attachment to caregivers, sense of self, symbolic/representational thought, peer relations and adaptive school functioning are all impacted upon. Therapeutic progress can be measured by the extent to which the child relives and can move beyond each of the earlier phases until the stage appropriate to the child's current maturational level is achieved (Haworth, 1964). The child is able to recapture those phases of former development which have not been fully assimilated into the child's present, incomplete state of maturing.

Assessing Cognitive/Developmental Level

Since emotions enhance, propel, and occasionally impede development, they deserve careful consideration and nurturing on the part of the adults who have chosen to work with children. It is clear that play can be a window to children's emotional lives and that it serves as a diagnostic as well as a curricular tool. Both the context (i.e. style) and text (i.e. thematic content) of dramatic play can tell us: a) where children are developmentally; b) what they might be grappling with emotionally; and c) where there could be emotional

interference. These communications can then be used to further children's emotional growth (Curry & Bergen, 1988). Through observation of the child's play the child play therapist can assess the child's cognitive-developmental level, as well as emotional issues.

Studies have shown that child abuse has severe developmental consequences, regardless of the particular area of development being studied (Farber & Egeland, 1987). Findings across various studies have found that a disproportionately large number of abused children fall below average on measures of intelligence (Morse, Sahler & Friedman, 1970; Sandgrund, Gaines, & Green, 1974). Further, evidence is increasing that traumatic experience, as well as psychosis, can have powerful, long lasting, possibly even permanent, effects on the developing organism (Van der Kolk, 1987).

Differences in Play Styles

Non-traumatized Children

The child's temperament and personality style need to be taken into consideration along with whether or not they have been traumatized. For example, social orientation exhibited in play is related to cognitive styles (Bergen, 1988). Children who have been identified as field dependent (i.e. gaining their information from people) or field independent (i.e. focusing on information in the inanimate world) show differences in play styles. Saracho (1985) suggests that a strong relationship exists between play and cognitive styles, with those children who are field dependent being more likely to engage in parallel, associative and cooperative play and those who are field independent being more likely to prefer solitary play. There are also personality differences in the dimension of "playfulness" (Lieberman, 1965). Intelligence level and characteristics of the home environment also appear to be related to children's playfulness (Barnett & Kleiber, 1984). Gender differences also add another dimension, in that activity levels for preschool boys are reported as higher, with girls engaging in more sedentary play (Maccoby & Jacklin, 1974). There are also individual and cultural differences in the way language is used in play. Individual styles of language ability affect levels of pretend play. Object-oriented and feeling-oriented speakers show different levels of pretend play, with expressive (feeling) children showing more pretend play. Individual differences in disposition to fantasy play are evident by age 3 or 4 (Singer, 1973). High and low fantasy children do not differ by sex or IQ but do differ on ability to delay gratification and on measures of creativity. In five-year-olds, high fantasy predisposition is related to originality, spontaneity, verbal fluency, ideational fluency, and flexibility (Pulaski, 1970).

Non-traumatized children will more easily make conversation and tend to discuss their world as it exists for them. They tend to talk more openly, spontaneously and directly, talking about their friends, teachers and important aspects of their life, even if shy and needing to "warm up" to the adult. Negative feelings may often be expressed directly, with the child playing out in a free and spontaneous way their feelings until relief and satisfaction are achieved (Moustakos, 1959).

Traumatized Children

Trauma overwhelms the child's usual coping abilities. Often they cannot play or their play does not heal them. They may remain silent in their first few sessions, speaking only with great difficulty to the therapist. However, other traumatized children may engage in a non-stop flow of questions and exchanges during their first sessions. They may attack or threaten to attack and may set up barricades, real and emotional, to keep the therapist from coming close to them. They may be cautious and deliberate in their actions, lacking spontaneity (Moustakos, 1959).

Special Areas of Consideration for Traumatized Children

Aggression in Non-traumatized Children:

Aggressive imagery appears in the play of most young preschoolers in unmodulated, barely disguised and stereotypic depiction of monsters or wild animals with focus on teeth and claws (Curry & Bergen, 1988 p. 118). Furthermore, preschoolers and children on into elementary school years engage in rough-and-tumble play similar to that of hostile behavior (e.g. running, chasing, wrestling, jumping, falling, hitting). However, these behaviors are accompanied by signals (e.g., laughter, exaggerated movement, open rather than closed hands and faces) that indicate "this is play" (Bateson, 1956). This type of play is often hard for adults, both because they are not always able to distinguish it from aggression and also because the increasing levels of arousal that it promotes may cause an escalation that is difficult to control (Aldis, 1975).

Prosocial and aggressive behaviors may go together in some preschoolers (Radke-Yarrow & Zahn-Waxler, 1976). Those children that exhibit the most prosocial behaviors often also show a high level of aggressive behaviors (Friedrich & Stein, 1973). Children who display both these characteristics are more socially active in general. Four year-olds with high levels of hostile aggression seem to lack perspective-taking ability, seeing others' actions as hostile to them even when they are not (Curry & Bergen, 1988, p. 127).

Preschoolers who are above average in aggression in play are more likely to be influenced by aggressive television programs (Friedrich & Stein, 1975).

School-age children will use dramatic play to test out many fearful fantasies under the safe guise of play. Arnaud (1971) notes that normal children will heavily invest in play and role enactment. Their play will usually be "blood and thunder melodramas, dripping with gore, featuring ambush and attack, killing and death" (p. 11). Arnaud further states that the play is often composed of ghosts, statues that come to life, "grisly folk heroes (e.g., Dracula), vampires, and people who turn out to be very different from what they purport to be" (p. 11).

Aggression in Traumatized Children:

Howe and Silvern (1981) identified differences in play therapy behaviors of aggressive, withdrawn and well-adjusted children. Aggressive children had frequent play disruptions, conflicted play, self-disclosing statements, high levels of fantasy play, and aggressive behavior toward the therapist and toys. Withdrawn boys were identified by their regression in response to anxiety, bizarre play, rejection of the therapist's intervention, and dysphoric content in play. Well-adjusted children exhibited less emotional discomfort, less social inadequacy, and less fantasy play. However, withdrawn girls could not be differentiated from well-adjusted girls.

Language and Communication

Children who have been traumatized may find that their feelings generally overflow and they need limit setting and calming techniques to help contain these feelings. The children may be unable to talk about things and may be unaware of their difficulty in identifying, containing and expressing feelings. In addition, other factors may contribute to difficulties in communication such as parental disinterest or even retaliation if the child openly expresses feelings (James, 1989). Emotional communication may not be valued by the family or encouraged. Personality style or being shy and withdrawn can also be a factor. In the case of the loss of a parent or sibling (by death or divorce), or removal of the child or parent due to sexual or physical abuse, the family environment may not be able to deal with the child's intense feelings, or be able to offer the consistency and reliability that the child needs. The traumatized child may display excessive dependency or become needy, demanding, and/or whiny and constantly search for support from the therapist, or teacher (James, 1989).

A child from birth to two years of age cannot selectively attend to stimulation. They are more in tune kinesthetically, auditorily, and visually (Athey, 1988). The normally developing child responds to smell, sound, and movement. Once language is acquired, children make a shift in their ability to tune out stimuli. By five and six years of age, the child is learning more by verbal means than experientially (Athey).

However, because trauma impacts a child's language and cognitive development, the therapist must focus interactions more in the experiential than verbal sphere (Schaefer & O'Connor, 1983). Nevertheless, language should be used to help the children understand their social and emotional functioning. The therapist may need to gear down language, use simpler words and shorter sentences. By pairing language with experiences, the traumatized child may be able to generalize concepts and understanding quickly (Schaefer & O'Connor, 1983).

A child who has difficulty with a concept, such as the death of a parent, may continue to have the same difficulty at each developmental shift, as concepts change. However, if language is used in the beginning of therapy to identify these issues clearly, it facilitates consistent development and generalization and allows for reprocessing later on without the need to re-experience the events (Schaefer & O'Connor, 1983). Direct modeling, reinforcement, and teaching of a particular term or concept can help facilitate communication and in turn, help traumatized children understand feelings (Gil, 1993).

Many children have limited vocabulary to express their feelings or even identify feeling states. There are over 400 affect words, yet many children will respond with happy, mad and sad when responding to questions of what they are feeling. The following case example of Maria, demonstrates a way to help traumatized children identify and expand their vocabulary of feelings.

Case Examples

The following case examples are drawn from the author's personal experiences in working with traumatized children.

Case Example #1: Maria

Maria is a five-year-old girl who, when asked how she was feeling, would respond with happy or mad. Her facial expressions were also very limited and she often had one stone-faced expression regardless of the events occurring around her. In therapy she was introduced to "The Feelings Game". Small cards listing over 100 different feeling adjectives were placed into a bag and Maria had to select one of them. She was helped to read and understand the feeling word, encouraged to "try on" the expression on her face, and look into

a mirror and either act out or tell a story around the feeling. The therapist and Maria would take turns each session choosing cards and playing out the feelings. Within three months, Maria's affective range and vocabulary had increased dramatically.

It is important to keep in mind that there is a developmental sequence involving children's understanding of feelings. Specifically, the very young child does not realize that feelings can be hidden, whereas latency aged children develop the belief that one can consciously control emotions and actively set aside negative feelings from one's mind. It is not until adolescence that an appreciation for the unconscious emerges (Schaefer & O'Connor, 1983).

There are also developmental differences in children's ability to appreciate that two seemingly contradictory feelings, for example, happy and sad, can coexist simultaneously. Children first deny that such feelings can coexist, then acknowledge that they can occur sequentially, and eventually appreciate the fact that they can simultaneously occur. The child's most difficult conceptual task is to realize that they can have two opposing feelings, say love and anger, toward the same person at the same time (Schaefer & O'Connor, 1983). Children can learn the concept of ambivalence before they can express it or act it out. Through the use of drawings they can get the idea that feelings can exist simultaneously as seen in this next example.

Case Example #2: Nick

Nick was a 10-year-old boy who often would walk around with a smile on his face, appearing happy, but at the slightest frustration or teasing by a peer he seethed with anger, ready to fight. In therapy, he often angrily spoke of his longing for his mother to get off drugs and become the nurturing and protective mother of his dreams. When asked to explore his feelings, Nick had difficulty expressing his ambivalence. The "Gingerbread Person" drawing was helpful for him. A drawing of a gingerbread person shape on paper was given to Nick. He was asked to list several different feelings he might have, and then to put a color that would identify each feeling next to the feeling word. Nick then was asked to think of an experience where he had lots of feelings at once, and to color in on the body of the drawing where each feeling might be. When he finished, Nick was able to quickly see how his ambivalence was felt within himself, and that the smiling face of his drawing masked his emotions of fear, loneliness and love.

Sexual Behavior

Sexual behavior in children can cause uncertainty in the therapist because of the relationship between sexual abuse and sexual behavior. One of the problems faced by clinicians in assessing children's sexual behaviors is the lack of current normative data on the development of children's sexuality. Sexual behavior in children can be sorted into a number of categories, all of them having an adult behavior correspondence. Freidrich, Fisher, Broughton, Houston and Shafran (1998) categorized them as follows: adherence to personal boundaries, exhibitionism, gender role behavior, self-stimulation, sexual anxiety, sexual interest, sexual intrusiveness, sexual knowledge, and voyeuristic behavior. In their study of 1,114 two-to-twelve year old children who were not sexually abused, a broad range of sexual behaviors were exhibited. Sexual behaviors that appear to be the most frequent include self-stimulating behaviors, exhibitionism, and behaviors related to personal boundaries. The researchers found two-year-olds to be relatively sexual (compared with 10-12 year olds) and noted that children become increasingly sexual up to age five, when frequency drops. Another drop occurs after age 9, although 11-year-old girls show a slight rise in sexual behavior, primarily coming from an increased interest in the opposite sex. At age 12, boys also show a similar slight increase for the same reasons. Additional findings were noteworthy. The total number of hours in day care per week contributed to a clinically significant increase in reported child sexual behavior in children with no known history of sexual abuse. Also, parents who reported a more relaxed approach to co-sleeping, co-bathing, family nudity, and opportunities to look at adult movies and witness sexual intercourse, reported higher levels of sexual behavior in their 2-12-year-old children. Behavior of the children was reflective of the context in which they were raised. Houston and Shafran also found that mothers with more years of education and who reported their belief that sexual feelings and behavior in children was normal, reported more sexual behavior in their children.

This study is helpful in identifying the normal behaviors across gender and age ranges. It allows therapists, as well as physicians or other practitioners, to be able to inform parents, for example, that simply because a 5-year-old boy touches his genitals occasionally, even after a weekend visit with a noncustodial parent, it does not mean he has been sexually abused. Rather, it is behavior that is seen in almost two thirds of boys at that age.

Sexually abused children often develop an excessive and abnormal interest in sex, an interest that is frequently expressed in precocious sexual activity (Gil, 1991). Through their work with normal and troubled children, Sgroi, Bunk, and Wabrek (1988) outlined a developmental framework for children's sexuality. Masturbation and looking at others' bodies occurs in children in the 0-5 year range. Children in the 6-10 age range will masturbate, look at others'

bodies, sexually expose themselves to others, and sexually fondle peers or younger children in play or game-like activities. Children in preadolescence through adolescence (10-18 years) will masturbate, sexually expose themselves, be voyeuristic, engage in open-mouth kissing, sexual fondling, simulated intercourse, and sexual penetration behaviors and intercourse. Adolescents may engage in frequent sexual talk, exposure to others, sexual curiosity, sex play with peers involving genital play and comparison, and early heterosexual interest (Crenshaw, 1993).

Berliner, Manaois, and Monastersky (1986) report that pathological sexual behaviors in children are distinguishable from developmentally appropriate sexual play by examining the dimension of severity. Sexual behaviors considered inappropriate can include persistent, public masturbation that can cause pain or irritation, touching or asking to touch others' genitals, excessive interest in sexual matters (reflected in play, art or conversation) and sexually stylized behavior imitative of adult sexual relationships. An additional characteristic of many sexualized children is a disinhibition of masturbatory behavior. A child who has not been sexually abused will abruptly stop masturbating when someone enters the room; sexually abused children, possibly having learned the sexual behavior with another person, may continue to masturbate.

Gil (1991) reports that the most severe type of sexualized behavior is coercive, including the use of physical force and resultant injury. Children's sexual behaviors tend to progress over time, with extreme behavior being indicative of psychological disturbance. She further states that premature sexual activity in children suggests two possible stimulants: experience and exposure. In addition, the therapist must keep in mind that the child may have experienced sexual contact with an adult or older child and may be mimicking the learned behavior, or the child may have been overstimulated by exposure to explicit sexual activity and may be acting this activity out.

The therapist should consider a developmentally sequenced type of treatment. Sequenced treatment (James, 1989) is necessary because past traumatic events will have different or additional meaning as the child matures. What was once experienced as generally confusing or uncomfortable may evolve into feeling shameful or exploited at a later time. Children who have been sexually abused may initially experience physical excitement and satisfaction of a reward or heightened stature as a result of sharing the secret of sexual abuse with the adult. However, at a later developmental stage the child may begin to experience guilt feelings for having enjoyed, or at least not resisted the experience. The child may further feel shame and feel responsible for causing the removal of a parent from the home. Fears around sexual identity and worries about becoming a perpetrator may emerge later as the child

enters puberty. Consequently, the therapist needs to lay the groundwork that a return to therapy may be needed as additional issues surface during later developmental stages (James, 1989).

Summary

Therapists need to be aware of developmental considerations when working with children in play therapy. Therapists at times can become complacent in assuming that the presenting problems of a child reflect trauma, when in fact, they may also indicate normal development. By having a theoretical understanding of development across the dimensions of the stages of play, the contrast between traumatized and non-traumatized children in expression of aggression, language and communication, and sexual behavior, the therapist is better able to assess the child's developmental level and lags. Play therapy techniques geared to the child's developmental arrests and regressions can help the child work through the impact of trauma, which leads to developmental advancement.

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Special Section: Research in Play Therapy

Introduction

In 1994, a play therapy research program was initiated as part of the Alfred University School Psychology Program. The goals of this research program were to develop and implement projects which addressed the shortcomings of past play therapy research, and to provide empirical evidence supporting or not supporting some of the current practices and claims regarding play therapy. Projects were initiated by both faculty and students on specific techniques, therapeutic outcomes, process variables, and training practices. A number of these studies were recently completed and are now entering the play therapy research literature. This section presents the results of two of these investigations as examples of the current state of play therapy research. The third article discusses directions for future research in this field.

“ *Play is the child's work.* **”**

—MARIA MONTESSORI

Play Therapy Training Practices for School Counselors: Results of a National Survey

Jay Cerio

Terry Taggart

Lori Costa

This article describes the results of a national survey on training of school counselors in play therapy. The survey was completed by school counselor educators. Information was obtained on the amount and format of training, use of practice, and beliefs of trainers about play therapy. Responses to the survey suggest that while trainers endorse the usefulness of play therapy, little more than half of counselor education programs offer training in this approach, and most training is limited to general information about play therapy.

Play therapy is a child counseling approach with roots extending back to Sigmund Freud's work with Little Hans (Freud, 1909/1955). The birth of the intentional use of play for therapeutic purposes is usually attributed to Hug-Hellmuth (1921), with such pioneers as Anna Freud (1946) and Melanie Klein (1955) expanding on this early work. The popularization of this approach can be traced to Virginia Axline's development of client-centered play therapy (Axline, 1947) and Clark Moustakas's work with relationship therapy (Moustakas, 1959). Later commentators on play therapy have sought to expand understanding and application of this approach (Donovan & McIntyre, 1990; Gil, 1991; Landreth, 1991; O'Connor, 1991; Schaefer & O'Connor, 1983; Webb, 1991). In particular, there has been a push for the use of this approach in school settings during the past decade (ASCA, 1993; Landreth, 1991). The subject of this article is the training provided to school counselors to prepare them to use play therapy.

Play Therapy Training

Until recently, there has been little or no research on the training of child practitioners in the use of play therapy. For the most part, it was assumed that "the majority of professionals currently practicing play therapy have had little or no training in play therapy" (Landreth, 1991, p. 104). This observation is supported by the few studies that have focused on training. Wilson and Rotter (1980) in a survey of a small sample of K-8 school counselors found that only 29 percent of the respondents reported having any training in play therapy. Phillips and Landreth (1995) and Kranz, Kottman, and Lund (1998) conducted surveys of professionals who were connected with the Association for Play Therapy, thus, were focusing on samples that identified themselves as play therapists. Both studies found that the primary source of play therapy training was workshops that were not part of cohesive training programs. Participants in both studies indicated a desire for increased workshop, course, and supervision opportunities.

Beliefs about Play Therapy

In a follow up study using data from the sample of APT members used in their first study (n=1166), Phillips and Landreth (1998) examined beliefs of play therapists regarding play therapy. Respondents reported the effectiveness rate of play therapy, based on their observations, to be approximately 80 percent. They saw play therapy being effective with both internalizing and externalizing disorders, and least effective with organically based disorders, such as mental retardation and pervasive developmental disorder. Regarding therapeutic factors that determine the success of play therapy, a large percentage of respondents (89%) indicated that they saw the relationship as the most important factor. A relatively small percentage (38%) believed that the "child's willingness to play" was a primary curative factor.

With the exception of the Wilson and Rotter (1980) study, little information exists concerning the preparation of school counselors for using play therapy as a counseling approach with children. Given that school counselors are typically first line service providers, and that there is a push to use play therapy in school settings, it seems reasonable to examine the status of play therapy training within school counseling programs. The purpose of this study is to provide information which will add to the knowledge regarding the training of school counselors in play therapy. Specific questions which will be investigated are: What percentage of programs is providing training in play therapy? What is the format of the training being provided? What is the content of the training being provided? To what degree are practices included as part of the training protocols of graduate programs? In addition, since it is logical to assume that counselor educators' beliefs about play

therapy will influence whether or not such training is offered, this study will also examine the beliefs and attitudes of trainers regarding providing training in play therapy.

Method

Participants

Participants were representatives of 117 school counseling training programs listed in *Peterson's Guide to Graduate Programs* (Peterson's, 1996). The 117 programs represent those trainers who returned the survey (out of 435 programs), yielding a 27% response rate. The regional breakdown was as follows: Northeast 10%; Mid-Atlantic 21%; Southeast 30%; Midwest 24%; Mountain/Southwest 4%; and West 12%. Fifty-two percent of the programs were located in urban areas, with 17 percent in suburban and 29 percent in rural settings.

Few of the programs responding (8%) were located in colleges enrolling less than 2,000 students. Twenty-five percent were located in medium-size institutions (2,000 to 5,000 students), with the majority (45%) located in colleges with enrollments greater than 10,000 students.

Instruments

Trainers Survey. A survey of practices for providing training in play therapy was developed specifically for this study. The first part of the survey included items concerning background demographic information including geographic location, setting (urban, suburban, rural), size of college, and type of college. The second part of the survey addressed training issues including training provided, format of training, and content of training; types, formats and locations of practica; and background and experience of trainers. The last part of the survey included items concerning trainers' beliefs about play therapy which respondents were asked to rate on a scale from "strongly agree" to "strongly disagree."

Procedure

The trainers survey was mailed to directors of school counseling training programs in January, 1996. Reminder postcards were sent to non-returners approximately four and seven weeks following the original mailing.

Data Analysis

Percentages were calculated for responses to all items. Statistical analyses were conducted to examine differences in training practices related to setting, type of college, date that degree was received, and type of degree program. Additional analyses were conducted based on trends detected in the first order analyses.

Results

Training Practices

The results of the survey are summarized in Table 1. Of the programs responding, 83 percent indicated that courses in play therapy belong in school counseling training programs. However, only 55 percent of programs offer some form of training in play therapy, with 3 percent offering required courses and 9 percent elective courses. The majority of programs that offer play therapy training (21%) do so as part of other counseling courses. Of the programs reporting that training in play therapy is offered, 66 percent indicated that it is limited to one-quarter or less of a course, 19 percent reported that they devote between one-quarter and one-half of a course to this approach, and only 15 percent indicated that they utilize more than half a course for play therapy training. Aside from lack of faculty with expertise (14%) and funding issues (10%), there were few barriers to offering play therapy training.

Trainers were also asked about the content of the training. Their responses indicated that for the most part, training in play therapy consists of a general overview of the approach (43% of programs), with a small number of programs offering training in specific approaches, such as child-centered (7%) and developmental (1%) play therapy. Only 15 percent of respondents reported that a play therapy practicum experience is available within their programs, with only about half (7%) requiring such an experience. The practica in half of these programs ($n=7$) involves 20 contact hours or less of play therapy experience. Only four programs require 150 or more contact hours or the equivalent of a semester long basic practicum. Thus, much of what programs label "training" in play therapy consists of minimal exposure to general information about this approach.

The last area examined by this portion of the survey was the background of the faculty who provide play therapy training. Seventy-three percent of programs that offer some form of play therapy coursework reported that the instructors were trained in play therapy, with 49 percent of these still practicing. Thirty-two percent of the course instructors had four to 10 years

of experience, and 45 percent were reported to have more than 10 years of experience. Similar levels of training and experience were reported for practicum supervisors, 77 percent of whom were trained in play therapy and 43 percent of whom had more than 10 years of experience.

Trainer Beliefs about Play Therapy

The second part of the survey consisted of 16 statements about play therapy which respondents were asked to rate on a five-point Likert-type scale from "strongly disagree" to "strongly agree." After reviewing the results, a decision was made to collapse the responses into three categories: agree, neutral, and disagree. A summary of responses is provided in Table 2.

There was general agreement among trainers regarding the therapeutic usefulness of play therapy, with large majorities agreeing with the statements, "Play therapy is the natural medium of expression for children," (91%); "Children are able to resolve unpleasant feelings through play," (84%); "Children are able to resolve internal conflicts through play," (82%); and "I think play therapy works," (88%). There was less agreement about the actual therapeutic factors operating in play therapy evidenced by responses to, "The therapeutic part of play therapy is the relationship," (agree=57%; neutral=32%); and "The therapeutic part of play is the symbols or metaphors used by the child," (agree=58%; neutral=29%). However, there was agreement that play therapy in and of itself is therapeutic, with 79 percent of respondents disagreeing with the statement, "Play therapy is no more than a placebo," and 71 percent agreeing with the statement, "Play therapy is therapeutic."

Trainers see play therapy as being only slightly more useful with internalizing problems (agree=13%; disagree=43%) than externalizing problems (agree=8%; disagree=36%). But a substantial number of neutral responses to each of these statements suggests that there exists some uncertainty regarding the types of problems with which trainers believe play therapy might be more useful.

A final set of items addressed the use of play therapy in school settings. Trainers generally agreed that schools are appropriate settings for the use of this approach (agree=62%; disagree=12%). On the other hand, 48 percent of the respondents agreed (vs. 18% disagreed) that school counselors are not adequately prepared to use play therapy. This is consistent with the training information provided in the first part of the survey.

Discussion

The purpose of this study was to provide up-to-date information on the format and content of play therapy training in the field of school counseling and on trainers' beliefs about play therapy. Some interesting differences were evident between this sample of counselor educators and the sample in the Phillips and Landreth (1998) study which consisted of professionals who identified themselves as play therapists. First, few of the school counseling programs indicated that child-centered approaches are a focus of play therapy training versus nearly one-quarter of the Phillips and Landreth sample. Second, a much smaller percentage of the school counselor educators viewed the relationship as the key therapeutic factor in play therapy. The play therapist sample identified the relationship as the most important therapeutic factor in play therapy. On the other hand, the counselor educator sample appears to view children's play as the primary therapeutic factor in play therapy, evidenced by high percentages of agreement on items addressing various play phenomena. A surprisingly small percentage of the play therapist sample indicated that "willingness to play" (Phillips & Landreth, p.21) was a primary curative factor.

Most of the trainers who responded to the survey seem thoroughly convinced that play therapy is a useful counseling approach with children. Trainers see play therapy as facilitating the expression of emotions and the resolution of conflicts, and as being generally therapeutic. While an overwhelming majority believe that play therapy works, respondents did not see it as being more beneficial with externalizers versus internalizers. This finding is consistent with that of Phillips and Landreth (1998).

A remarkable finding is that while a large percentage of trainers felt that play therapy training belonged in school counseling programs, only about one-half of the training programs make such training available, and just a handful require such training. In addition, the training that is offered by most programs is quite minimal, consisting of general information about play therapy provided in less than 20 contact hours of instruction. Few programs offer, and even fewer require, practica that would allow students the hands-on type of experiences that are so critical for developing practical skills, understanding, and self-confidence.

At the same time, trainers see schools as settings in which play therapy would be useful, but do not feel school counselors are adequately prepared to utilize this approach. In light of all of this information, one has to ask, "Why not?" It appears that trainers believe that play therapy is a valid approach for counseling children and that there are few barriers standing in the way of offering training in this area. So, what is stopping programs from doing so?

Implications for Training

School counseling programs need to consider providing more extensive training in play therapy. This will be particularly important in programs that prepare students to work as elementary school counselors or child counselors in community settings. Instruction needs to go beyond general information and encompass such microskills as therapeutic responding and limitsetting in play therapy. Practicum experiences should also be incorporated into this training to provide students with opportunities to apply play therapy skills with children. This will allow students to develop the practical knowledge-base and self-efficacy which are so important when beginning careers in counseling. In short, programs need to provide more training and practice opportunities in play therapy.

Summary

The purpose of this study was to expand our knowledge about play therapy training by investigating the amount, format and content of training being provided to school counselors. The results of this study indicate that while counselor educators see play therapy as a useful child counseling approach, training programs give short shrift to this modality. Consequently, most school counselors are not adequately prepared to utilize this approach.

School counselors are among the first counseling service providers who children experiencing problems will see. School counselors are typically much more accessible to children than counselors in agency settings, having the advantage of not having to rely on others to transport children to their counseling sessions. Thus, it would make sense to provide training to school counselors, especially those who have the option of working with elementary level children, in child-focused counseling approaches. It seems clear that if the field as a whole is committed to producing professionals who will be effective in providing services to children, then training programs should reassess how they are preparing their graduates to use play therapy, one of the primary child counseling approaches.

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Table 1
Play Therapy Training Information

Total N = 117			
Question	N	Responding	%
Do courses in play therapy belong in a school counseling program?			
Yes	97		83
No	12		10
No Response	8		7
Barriers to offering play therapy courses:			
None	40		34
No faculty w/expertise	16		14
Funding	12		10
Philosophical/Research	33		
Reservations			
Other	16		14
Do you provide instruction in play therapy?			
Yes	64		55
No	45		39
No Response	8		7
Type of instruction:			
Required Course	4		11
Elective Course	10		9
Part of Required Course	25		21
Other	7		6
If instruction is part of a course, percentage of course devoted to play therapy:			
≤ 25%	24		21
25 - 50 %	7		6
> 50%	5		5
Primary play therapy approach that is taught to your students:			
General Overview	50		43
Child-centered	8		7
Developmental	1		1
Psychodynamic	0		0
Cognitive-Behavioral	0		0
Combinations	4		4
Other	3		3

Total N = 117

continued

Table 1, continued

<u>Question</u>	<u>N</u> <u>Responding</u>	<u>%</u>
Level of expertise of the course instructor:		
Trained in Play Therapy, Practicing	32	27
Trained in Play Therapy, Not Practicing	15	13
Courses in Play Therapy	5	4
Self-taught	13	11
Amount of experience of course instructor:		
No Experience	4	3
1 - 3 Years	12	10
4 - 10 Years	21	18
> 10 Years	29	25
Does your program provide a practicum in play therapy?		
Yes	18	15
No	74	63
No Response	25	21
Is the practicum experience:		
Required	8	7
Optional	15	13
Hours of training in practicum:		
< 20	7	6
20 - 100	3	3
100 - 150	2	2
> 150	2	2
Hours of supervision in practicum:		
1 hour	9	8
2 hours	2	2
3 hours	5	4
4 hours	1	1
Level of expertise of supervisor:		
Trained in Play Therapy, Practicing	17	15
Trained in Play Therapy, Not Practicing	2	2
Amount of experience of supervisor:		
1 - 3 Years	3	3
4 - 10 Years	11	9
> 10 Years	10	9

Table 2
Trainers' Beliefs about Play Therapy

Total N = 117			
<u>Item</u>	<u>% Agree</u>	<u>% Neutral</u>	<u>% Disagree</u>
Play is the natural medium of expression for children.	91	2	2
Children are able to resolve unpleasant feelings through play.	84	6	4
Play therapy is no more than an placebo.	9	6	79
Play therapy helps children to relax so that they will talk more in counseling.	76	10	7
Children are able to resolve internal conflicts through play.	82	9	2
The therapeutic part of play therapy is the relationship.	57	32	5
The therapeutic part of play is the symbols or metaphors used by the child.	58	29	6
Play therapy is too inferential.	7	13	74
Play therapy is more useful with internalizing type clients.	13	36	43
I think play therapy works.	88	3	2
Schools are ideal settings in which to use play therapy.	62	20	12
Play therapy is more useful with externalizing type clients.	8	48	36
Play therapy simply provides the basis for implementing interventions.	21	32	40
Play therapy should not be used at all.	3	2	87
Play therapy is therapeutic.	71	15	7
School counselors do not have adequate training for using play therapy.	48	21	18

“ *Rocket science is child's play
compared to understanding
child's play.* **”**

-UNKNOWN

A Comparison of the Effects of Two Family Play Therapy Activities on Child Participation, Comfort, and Activity Preference in Family Therapy

Karin Lebitz Giudici

Jay Cerio

The purpose of this exploratory study was to examine the effects of two family play therapy techniques and a standard family therapy interview on children's participation in therapy, clients' comfort with the therapeutic situation, and preference for a particular technique. Data was gathered from members of 14 families who volunteered to participate. The observational data of participation showed children to be more actively engaged and less off task during the puppet and drawing activities than the standard interview. Children were more passively engaged during the standard family therapy interview. The family drawing activity had a positive influence on mothers' comfort with the therapeutic situation, but none of the activities differentially affected comfort ratings of fathers or children. The puppet and drawing activities did have a significant positive impact on children's activity preferences, the play activities being ranked as more enjoyable than the standard interview. There were no differences among the three activities in parent rankings.

Introduction

Since the 1700's, play has been recognized as an important factor in the child development process, and as important as a means of understanding children (Landreth, 1991). Despite this knowledge, professionals in the early days of the psychotherapy field attempted to impose on children the methods of analysis and treatment used with adults. It was not until the early 1900's

that the first case detailing a specific therapeutic approach used with a child was published (Freud, 1909/1955), and it was not until 1919 that play was used as a form of therapy with children (Hug-Hellmuth, 1921). Since that time, a variety of play therapy approaches have been developed, including psychoanalytic play therapy (Freud, 1946; Klein, 1955), relationship play therapy (Allen, 1934; Taft, 1933), release play therapy (Levy, 1938), and non-directive play therapy (Axline, 1947), to name just a few. Most play therapies fall on a continuum ranging from directive approaches, such as release therapy, to non-directive approaches, such as child-centered play therapy. Whether directive or non-directive, play therapy was developed in response to the need to address issues pertaining specifically to children.

General agreement exists among practitioners of play therapy that the use of play is an effective means of communicating on a level that is developmentally appropriate for children (Bettelheim, 1987; O'Connor, 1991; Schaefer, 1985). Play therapy creates a safe, empathic relationship between the child and therapist which allows the child to express feelings, attitudes, conflicts, and traumatic experiences that cannot be expressed through the use of language. Children reveal these issues through their actions and play (Landreth; O'Connor).

The basic underlying tenet of most play therapy approaches might be called the "individual change assumption," which is really an extension of individual psychotherapy approaches used with adults. This assumption is that an individual can change through the individual encounter between client and therapist. However, child clients function under circumstances that are quite different from adult clients. Children must function in a world controlled by adults: parents, teachers, caseworkers, and the like. Children neither function in a vacuum nor have the same freedom to make choices that adult clients do. Thus, what happens when a child's home life perpetuates problems for which the child is being treated? When a child's home life is problematic, the benefits of individual therapy may be lost. Family therapy is designed to address issues that occur within a family context.

The field of family therapy developed in the 1950's in response to general disaffection with traditional psychotherapy approaches (Nichols & Schwartz, 1991) and research regarding the influence of families on the functioning of schizophrenics (Jackson, 1967; Lidz & Lidz, 1949; Wynne, 1958). Family therapy has become a useful intervention with a wide variety of family and individual problems. The primary goal of family therapy is to stimulate change among all family members, increasing the potential for improvements to be maintained over time (Nichols & Schwartz). A number of different family therapy approaches have been developed over the years which have been categorized as either interventionist or non-interventionist approaches (Minuchin, Lee, & Simon, 1996). Interventionist models such as strategic

therapy (Haley, 1976; Madanes, 1981) and structural therapy (Minuchin & Fishman, 1981) emphasize general reorganization of family structure and dynamics as the route to change. Non-interventionist approaches, such as solution-focused therapy (O'Hanlon & Weiner-Davis, 1989) take the "if it ain't broke, don't fix it" approach. That is, these approaches tend to focus on non-intrusive, readily accessible interventions for addressing the presenting problem and not on family reorganization.

The concrete methods of family therapy—specifically, what happens in therapy sessions—have been geared toward adults and older adolescents. Younger children may be present during sessions, however, their mere presence does not imply that they are active participants in the process of family therapy. Although it can be subtle in form, young children are typically excluded during family therapy sessions. This is less a function of children's ability to contribute significantly to the therapy, and more a function of family therapists' resistance to utilizing children's input. This may be due to such factors as therapists' lack of training in child therapy (Korner & Brown, 1990), views that children are too distracting or that they lack the verbal skills to communicate effectively, and therapists' avoidance of re-experiencing painful memories from their own childhood (Bloch, 1976; Zilbach, 1986). At any rate, failing to include children in family therapy, even when they are present in the therapy room, is a relatively common occurrence.

Combining two traditionally exclusive disciplines, play therapy and family therapy, is a viable option for including children in family therapy, and, as a result should strengthen both approaches (Gil, 1994). Family play therapy involves families in pre-planned play situations, and is typically used in conjunction with other interventions. The primary focus of these techniques is to involve even the youngest children in the therapeutic process. Family play therapy combines techniques from both family therapy and play therapy in order to fully engage young children when working with families in therapy. The purpose of this study is to investigate the usefulness of family play therapy in achieving this goal. Specifically, the impact of two family play therapy techniques—the Family Puppet Interview (Irwin & Malloy, 1975) and a family drawing activity—will be compared in relation to involvement of children in therapy, and family members' comfort with and preference for one of these therapeutic techniques.

The Family Puppet Interview

Developed by Irwin and Malloy (1975), the Family Puppet Interview (FPI) is described by them as a strategy that "stimulates verbal and non-verbal communication, revealing how a family member mobilizes toward a goal or task" (Irwin & Malloy, 1995, p. 181). In the FPI, the family is provided with an

array of puppets and asked to develop a story which includes puppets chosen by each member. The process by which the family develops the story and actual themes expressed are evaluated to determine family dynamics and structure. Specifically, the FPI has been "particularly useful in viewing decision-making within the family, observing family patterns, and studying symbolic communication between and among family members" (Irwin & Malloy, p.182).

Unlike other techniques that do not fully integrate children into the family sessions, the FPI involves the entire family. Using the FPI conveys the message that children are important members of the family system. From the adults' perspective, the FPI allows them to enter into children's worlds, enabling adults to better understand and communicate with children on their level. The introduction of play to the family therapy setting can make family interactions more enjoyable and serve to reduce inhibitions and anxiety (Gil, 1994). Despite reported accounts of the FPI's potential benefits, existing literature on this technique is sparse, and the technique has not been empirically validated (Gil). Research involving the FPI has been in the form of clinical case studies and anecdotal reports of its effectiveness.

Method

Research Questions

What are the differential effects of the Family Puppet Interview, a family drawing activity, and a standard family therapy interview on:

- 1) Children's participation in family therapy?
- 2) Family members comfort with the therapeutic situation?
- 3) Family members' preferences for a specific technique?

Participants

Participants were members of 14 families who resided in a rural area of New York State. Families were recruited through advertisements in local newspapers and postings on electronic mail at two colleges. For inclusion in the study, families had to be comprised of at least one parent and one child between five and 12 years of age. This restricted age range was based on previous literature on the use of the FPI (Irwin & Malloy, 1975).

Of the families that volunteered, eight were two-parent families and six were single-parent households (one father and five mothers). Children ranged

in age from two to 13 years, with the mean age being 7.7 years. Four families were receiving services from a child guidance center, however, their participation in the research was not part of these services.

Measures

Child Participation Observations. Videotapes of family activities were observed independently by five observers to determine degree of involvement of children in the activities. Children's behavior was rated as either actively engaged, passively engaged, or off task. Passive engagement was defined as involving passive interactions between a child and family members or the interviewer, such as listening. Active engagement was defined as instances when the child was appropriately involved physically or verbally with other family members, the interviewer, or the task, such as answering questions, acting out story lines with puppets, or drawing pictures. Off task behavior was defined as physically or verbally behaving in a manner that was not related to the task, such as throwing puppets, drumming pencils, and speaking tangentially. Each observation was no longer than 15 minutes, with each minute divided into four 15 second intervals. Time point sampling was used, which meant that if a behavior occurred precisely at the end of an interval, it was recorded one time for that interval (Shapiro, 1996). Observers were blind to the purpose of the study.

Rating Scale: A rating scale was developed for the purposes of this study consisting of five statements designed to measure family members' enjoyment of and comfort with each therapeutic activity. Participants were instructed to respond to the statements on a five-point Likert-type scale, a rating of one being "highly disagree," and five being "highly agree." After completion of all three therapeutic activities, participants were asked to rank order the three activities from most to least liked.

Treatment Conditions

Standard procedures and scripts were developed for each family activity.

Family Puppet Interview (FPI). The Family Puppet Interview is a technique that involves family members in a story telling activity through the use of puppets. Each family was provided with approximately 20 hand puppets depicting people, animals, and fictitious characters. Family members were instructed to choose puppets that they would like to use to make up an original story. The family was told that they needed to decide how to develop their story and then act it out for the interviewer. The interviewer left the room and viewed the family on a television monitor while the story was developed. After 15 minutes or when the family developed a beginning to their story, the

interviewer re-entered the room and asked the family members to begin the story by having their puppets introduce themselves. When the family completed the story, the interviewer asked members to give the story a title.

Family Drawing Activity (FDA). The family drawing activity began with an invitation to family members to draw a picture together. The selection of what was drawn was open-ended, and the construction of the drawing relied on the efforts of one or all family members. Families were provided with a large piece of easel paper on which to complete their drawing. As with the FPI, the interviewer left the room and viewed the family on a television monitor. The interviewer returned to the room after 15 minutes or when the family had completed their drawing, and asked the family to give their drawing a title.

Family Therapy Interview (FTI). The family therapy interview, serving as a control procedure, also followed a standard format, consisting of a series of standard questions related to family background and family issues. Questions were directed to all family members and required oral responses. Each member was asked to answer the same question before the next question was asked. The initial order in which each family member was asked a question was randomized prior to administration. After the first question was set, the questions were then rotated in counterbalanced order. For example, if a question was asked first to mother then father then child, the next question was directed first to father then child then mother. The third question was directed to child then mother then father, and so on.

Procedure

Administration of family activities took place at a university-based child guidance center. Each activity was assigned to a separate room of the center, and the order of administration of the FPI, FDA, and FTI was counterbalanced. No more than 20 minutes was allotted for each activity with a five minute break between activities. All activities were videotaped. After completion of each family activity, interviewers asked family members to complete their rating scales separately. The interviewer read the rating scale and recorded responses for children with limited reading skills. Following completion of the final activity and rating scale, families were returned to the waiting room, thanked and paid \$10.00 for their participation. Families were contacted by mail and debriefed regarding the research after completion of the study.

Statistical Analysis

One-way analyses of variance (ANOVA) were computed for observational data of a group comprised of one index child from each family and for the

observations for all children. A series of one way ANOVAs was also used to analyze rating scale data separately for fathers, mothers, index children and all children. All post hoc comparisons were conducted using Dunn's test.

Results

Child Participation

The first research question asked if there were differential effects of the three family activities on degree of child participation in the activities. Separate ANOVAs were computed for passive engagement, active engagement, and off task behavior on percentage of intervals in which behaviors were observed. The analysis was divided between a group of index children and the mean observations for all children.

Passive Engagement. Results of the analysis indicated a significant difference across the three conditions for both the index children ($F(2,26)=16.14$, $p<.0001$) and total children ($F(2,26)=20.29$, $p<.0001$) groups. Post hoc comparisons showed that both the index children and total children groups were passively engaged more often in the family therapy interview than the drawing or puppet conditions, and more passively engaged in the FPI than the FDA.

Active Engagement. Results of the ANOVA indicated a significant difference across the three conditions in active engagement for the index children ($F(2,26)=19.70$, $p<.0001$) and total children ($F(2,26)=26.83$, $p<.0001$). Post hoc comparisons for the index children group show that these children were more actively engaged during the FPI ($M=48\%$) and FDA ($M=62\%$) than the FTI ($M=23\%$). There were no differences in engagement between the FPI and FDA for this group. Post hoc comparisons for the total children group indicated that children were significantly more actively engaged during the FDA ($M=60\%$) than the FPI ($M=43\%$) and FTI ($M=24\%$), and more actively engaged during the FPI than the FTI.

Off Task Behavior. The ANOVAs of percentage of intervals that the index children ($F(2,26)=4.54$, $p=.02$) and total children ($F(2,26)=6.03$, $p=.007$) groups were off task were significant. The post hoc comparison of the index children's data indicates that children in this group were off task more often during the FTI ($M=19\%$) than during either the FPI ($M=6\%$) or FDA ($M=8\%$). No differences were found between the FPI and FDA. Post hoc comparisons of the total children data shows that children were more likely to be off task during the FTI ($M=20\%$) than during the FDA ($M=9\%$). No differences in intervals off task were found between the FPI ($M=14\%$) and FTI or FDA.

Client Comfort

The second research question asked if any of the three family activities affected clients' comfort with the therapeutic situation. ANOVA results indicated a significant difference for the comfort level of mothers ($F(2, 24)=7.34, p=.003$). Post hoc comparisons indicated that mothers were more comfortable with the family drawing activity ($M=4.69$) than the Family Puppet Interview ($M=3.39$). No differences were found between the family therapy interview ($M=4.08$) and the other two activities. In addition, no differences were found in comfort level for fathers', index children's, and total children's ratings.

Activity Preference

The third research question asked if any of the three family activities would differentially affect clients' preference for one activity over another. Results of the one-way ANOVA on rankings of techniques revealed a significant difference in preferences of the index children ($F(2,16)=12.25, p=.001$). Post hoc comparisons indicated that index children ranked the Family Puppet Interview ($M=1.67$) and family drawing activity ($M=1.44$) as more enjoyable than the family therapy interview ($M=2.89$). No differences were found between the FPI and FDA. In addition, a trend toward significance was found for the rankings of the total children group ($F(2,18)=3.42, p=.055$), the FPI ($M=1.82$) and FDA ($M=1.72$) being ranked as more enjoyable than the FTI ($M=2.45$). No differences were found in rankings of mothers and fathers.

Discussion

The purpose of this exploratory study was to examine the effects of two family play therapy techniques and a standard family therapy interview on children's participation in therapy, clients' comfort with the therapeutic situation, and preference for a particular technique. Data was gathered from members of 14 families. The observational data of participation showed children to be more actively engaged and less off task during the puppet and drawing activities than the standard interview. However, children were more passively engaged during the standard family therapy interview. The family drawing activity had a positive influence on mothers' comfort with the therapeutic situation, but none of the activities differentially affected comfort ratings of fathers or children. In fact, the mean ratings of all groups indicated a moderate level of comfort with each activity. The puppet and drawing activities did have a significant positive impact on children's activity preferences, these being ranked as more enjoyable than the standard interview. There were no differences among activities in parent rankings.

Child Participation

It was expected that the play activities would yield the highest degree of active participation for children, and that the standard interview would result in more off task behavior. This is consistent with clinical assertions that play is an activity that involves children in the therapeutic situation (Gil, 1994; Zilbach, 1986). The drawing seemed to result in a high degree of active participation because children could draw while they were engaged in other behaviors. Therefore, some off task behaviors may have been masked by children being actively engaged and off task simultaneously. On the other hand, the lack of differences in off task behavior between the puppet activity and standard interview for the total children group may have been due to the children's need to explore and familiarize themselves with the puppets. It is probable that this time was recorded as off task since it was not related to choosing puppets for the purposes of developing a story.

Low levels of active engagement in the standard interview were expected, given that verbal communication is not as natural a form of communication as play for children. Relying solely on verbal exchanges of information seems to exclude children from the traditional family therapy situation (Bloch, 1976; Zilbach). Play is a means of fully engaging young children when working with families in therapy (Gil). The lack of differences between the puppet and drawing activities suggests that play, regardless of the type, keeps children actively engaged.

It is not surprising that the standard interview yielded the greatest amount of passive engagement in children. Children may have spent more time listening to others during the interview than verbally communicating. What is surprising is that the puppet interview did not elicit less passive engagement, and that the lowest amount of passive engagement was observed in the drawing activity. It seems logical to assume that puppets would engage children's attention more because they are toys and require manipulation. Parents did appear to be uncomfortable with the puppet task, which may have inhibited the planning and acting out of the story, and subsequently increased the degree of passive engagement. Also, parents showed an inclination to "take charge" which probably increased the children's passive engagement, as the children would sit back and watch parents direct the puppet activities.

Client Comfort

While anecdotal data suggests that the Family Puppet Interview is an activity that increases the comfort of family members with the therapeutic situation (Gil, 1994), the results of the family ratings did not support this. Mothers were more comfortable with the drawing than the puppet activity,

while no differences were evident in the ratings of other family members. A couple of factors may have influenced these results. First, drawing is a more familiar activity to adults than is playing with puppets. Everyone draws to some degree (e.g., doodling). Thus, based on the familiarity of the task, drawing may have been rated as more comfortable. Second, role differences may predispose mothers to be more comfortable with playing with their children, particularly when the play involves unstructured activities such as drawing. The mothers in the study, then, might have viewed the play activities as fairly natural extensions of interactions that occurred outside the therapeutic setting.

Activity Preference

The children in the study clearly preferred the play activities to the family interview. While there were no statistical differences between the puppet and drawing activities in this area, the drawing activity was ranked as slightly more enjoyable than puppet activity. This was consistent with the findings on participation, the drawing activity eliciting more active engagement and less off task behavior than did the puppet activity. At any rate, the findings for both activity preference and participation lends solid support to assertions that family play therapy techniques involve children more actively in family therapy (Gil, 1994; Zilbach, 1986), and that play is a developmentally appropriate means of connecting with children (O'Connor, 1991; Schaefer, 1985).

Limitations

Several limitations of this study should be noted. This was an exploratory analog study and, as such, used a small sample of participants who were not real "clients." The sample consisted of volunteers rather than randomly selected subjects, and was limited to families residing in a rural area of New York State. The self report measures used were developed specifically for this study and were not normed, which may have contributed to a degree of measurement error. Thus, caution must be used when generalizing the results.

Implications

Practice. The results of this study provide promising support for incorporating play activities into family therapy. While there was no conclusive evidence that one of the two play activities investigated was superior to the other, it does seem reasonable to recommend that counselors include some form of play activities when counseling families. The findings suggest that in doing so, counselors should use one of two general approaches. The first

would be to select an activity that is familiar to both parents and children, such as drawing. The second would be to give parents time to become comfortable with the counselor and play media that might be less adult-friendly, such as finger paints or playdoh. Once parents become comfortable, then the counselor could introduce a more structured family play activity that involved this media.

Research. The promising results of this study suggest that it would be fruitful to pursue research using larger samples of real clients. Research also needs to investigate other outcomes of family play therapy activities, such as the usefulness of these approaches in illuminating and changing problematic family dynamics. Finally, future studies should examine whether certain types of play are more useful in family therapy than other types of play, and if there are optimal points in the therapy process to introduce such activities.

Summary

There is a substantial amount of qualitative research on play therapy and family therapy, but only a small number of studies provides quantitative evidence of the effects of these approaches, as this one does. Rather than continue to base practice on assertions of experts, counselors need to utilize techniques that are empirically validated. Research that identifies useful and valid therapeutic techniques can only improve the effectiveness of counselors. The results of this exploratory study, hopefully, provides practitioners with just such evidence.

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Future Directions in Play Therapy Research

Jay Cerio

Helen Boehm-Morelli

This article discusses some of the shortcomings of past play therapy research, including problems with research design, measurement, conceptual biases, and meaningful outcomes. Suggestions are made for addressing these problems, as well as recommendations for future areas in which to pursue research on play therapy.

Play therapy has long suffered the reputation of being some sort of mystical, "touchy feely" activity, for which there is little evidence to validate its use as a viable form of psychotherapy. This reputation has been well-earned over the years, as practitioners of play therapy have relied primarily on anecdotal case studies and faith in the theoretical/philosophical perspectives of "experts" to guide their beliefs in the efficacy of this approach. Actual research on play therapy has been sparse, the designs problematic, and the findings inconclusive, providing further fuel for the naysayers to assert that play therapy is not a real form of psychotherapy. Complicating this debate is the recent, and often hostile, environment created by managed care, which demands that psychotherapy techniques be empirically validated in order to be covered by health insurance. This article will provide a brief overview of the current issues in play therapy research which can be separated into two areas. The first involves problems in methodology, which includes research designs, measures, and treatment integrity. The second encompasses conceptual biases and the relevance of outcomes that are measured. Suggestions will be offered on how to improve the state of research in this field.

Research Design

The Problem. Play therapy studies have typically failed to incorporate control groups or alternative interventions into their designs (Axline, 1947; Griffiths, 1971). This has made it nearly impossible to conclude that positive outcomes of play therapy are the result of anything more than spontaneous remission. While proponents of play therapy contend that the fact that client functioning improved after the introduction of play therapy provides evidence of effectiveness, this argument holds no *empirical* weight. Without a "no treatment" control group, we just don't know if that is the case. Related to this is the failure to include alternative intervention or placebo groups in play therapy studies. The lack of these comparison groups makes it difficult to determine whether or not play therapy is essentially different from play, and whether simply paying attention to children yields similar outcomes as play therapy.

Suggestions. Future studies need to incorporate both control groups and alternative interventions in order to address these shortcomings in research design. There are often ethical concerns that have hindered the use of control groups in between group designs, specifically that these type of designs deny clients access to treatment for a period of time. However, there are ways to create a control group without endangering the welfare of clients. In settings that utilize waiting lists because of high demand for services, children's functioning could be periodically measured between the time of initial referral and the first appointment. This would provide information regarding client functioning during no treatment waiting periods, within the confines of an agency's normal operating procedures.

Multiple baseline within subject designs are a second method of incorporating control conditions into studies (Keppel, 1982). In these designs, subjects serve as their own controls, based on measures of functioning that were completed before the initiation of therapy. This can be accomplished by again using a waiting list period as the baseline, or by establishing a pre-treatment period. Kazdin (1982) has stated that using a shorter period of time (2 to 3 weeks or sessions) provides an adequate baseline in these designs, and addresses the ethical concerns regarding withholding treatment.

These same types of designs would be useful for making comparisons between play therapy and placebo or alternative interventions. In the case of multiple baseline designs, counterbalancing of interventions helps to control for practice effects, the problem of an earlier intervention "paving the way" for the one that follows (Keppel). In counterbalancing, the order of interventions is varied. For example, the first subject participates in intervention A first, then B, then C. The second subject participates in B, then C, then A. The order for the third subject is C, A, B, and so forth. At any rate, incorporating

control and placebo groups into the designs of play therapy studies will be critical to the provision of any definitive data on the usefulness of this approach.

Measurement Issues

The Problem. Dependent measures that have been used in the past to assess the impact of play therapy were clearly deficient. The collection of relevant and objective data has been limited (White & Allers, 1994). Many case studies simply incorporated therapist report of improvement as the primary "measure." Other studies used non-standardized symptom checklists and client self-reports of improvement. Typically, only one source of data was used, be it client, parent, teacher, or therapist. These methods of measuring outcomes increases the potential for the Hawthorne (or placebo) effect to bias findings. This is the tendency for individuals to perceive that improvement is occurring simply because they know they are being studied and that an intervention might be used, whether or not actual change has occurred (Gay, 1976). This measurement problem has been a major criticism of play therapy outcome research, contributing to the perception that play therapy is nothing more than a placebo with no real therapeutic benefits.

Suggestions. Newer omnibus rating scales such as the Behavior Assessment System for Children (BASC) (Reynolds & Kamphaus, 1992) can partially alleviate this problem. These scales are designed to obtain data from multiple sources (self, parent, teacher), utilize aggregate ratings of behavior, are designed to assess patterns of both problem and adaptive behavior, and are normed on large, representative national samples. In order for scores to increase or decrease in a particular area, ratings of several different behaviors must change in a consistent direction. Scores are then compared with the normative data in terms of deviation from the mean. For research purposes, change can also be viewed in terms of consistency of ratings across reporters.

The use of direct behavioral observations is also important in establishing whether behavior change has actually occurred. Behavioral observations are more objective and concrete than ratings, and, thus, more immune to Hawthorne effect. Newer observation systems such as the Behavioral Observation of Students in Schools (BOSS) (Shapiro, 1996) and the BASC Standardized Observation System (SOS) now provide standard observation methods that are useful in research. The accessibility of videotaping also makes observations of larger groups of subjects possible, by reducing the need for observers to be present while the behavior is occurring. More observers can then be utilized to obtain this type of data.

Instruments like the BASC and techniques such as the BOSS help objectify measurement of change which helps control for Hawthorne effect. When an

intervention is implemented and positive change is reported consistently across raters, and actually seen by observers, then and only then can we conclude that the intervention has had some effect. Evidence such as this will certainly provide reliable data regarding the effects of play therapy.

Treatment Integrity

The Problem. Insuring the standard application of interventions—that is the integrity of the treatment being used—is not only a problem in play therapy research, but in most non-behavioral psychotherapy research. Treatment integrity allows researchers to evaluate whether or not a technique or method is effective, and helps to control for such factors as therapists' personal styles. Past play therapy studies typically have not established that methods have been used in standard ways across therapists and clients (Griffiths, 1971; Swartz & Swartz, 1985).

Suggestions. Establishing treatment integrity is often a labor and time intensive task that requires the standardization of methods in behavioral terms, and observation of interventions during implementation. The former typically requires the operationalization of therapist behaviors, development of manual type materials, face-to-face training, and demonstration of the consistent use of the method by therapists before initiating the research intervention. The latter requires periodic checks of therapist behavior during implementation of the intervention. These checks need to be conducted by independent observers who have no knowledge of the purposes of the research, and should be completed at different points of the research. It is particularly important that manipulation checks be done early enough in the research to allow researchers to retrain therapists who are deviating from the standard intervention protocol. It is also desirable to check every intervention session in order to eliminate any data that might be influenced by lack of consistency in the intervention. Current video technology has made it much easier to assess treatment integrity in play therapy research than in the past. Thus, it is important to utilize these tools to establish treatment integrity in order to produce solid, uncontaminated evidence of the usefulness of play therapy.

Conceptual Biases and Outcomes

Conceptual biases run rampant in play therapy research. This appears to be related to the powerful influences of non-directive, humanistic play therapy approaches (Axline, 1947; Moustakas, 1959) that were developed after World War II. These models, which emphasize the importance of client self-direction and self esteem in client functioning (Landreth, 1991), have impacted the way in which play therapy research is conducted and the

interpretation of research results. For instance, Axline, in her classic study of remedial readers, concluded that reading improvement was related to the development of congruence between ideal and real self, a Person-centered theory concept, and basically ignored the impact of reading instruction. It is probable that this same conceptual bias led to the acceptance of anecdotal case studies, presented within strict theoretical frameworks, (Barlow, Strother, & Landreth, 1985; Nystul, 1980) as demonstrations of play therapy efficacy. Finally, there was overemphasis on investigating the influence of play therapy on self esteem or self-concept (Crow, 1994; Elliott & Pumfrey, 1972; Griffiths, 1971), without much regard as to whether these areas influence other areas of functioning.

Suggestions. Phillips (1985), in a research review article, suggested that one of the most frequently occurring problems with play therapy outcome studies involved the objective measurement of meaningful outcomes. The first part of this statement, the need for more objective and comprehensive measures was addressed above. The second part, the need to examine outcomes that are more meaningful will require a shift from theoretically-based to behaviorally-based outcomes. Specifically, research needs to focus on outcomes that clearly demonstrate improvement in client functioning. Thus, rather than simply measuring the effects of play therapy on self-concept, research needs to determine whether self-concept is causally linked to specific areas of client functioning. Research also needs to investigate the efficacy of play therapy with specific types of problems, such as depression, anxiety, trauma, bereavement, aggression and anger management, and effects of divorce. By incorporating the improvements in research design, measures, and treatment integrity discussed above, and utilizing state-of-the-art statistical techniques, we will be able to more clearly assess therapeutic outcomes of play therapy.

Future Directions in Research Topics

With the recent growth in the play therapy field, other avenues of research would be useful and relevant to explore. Again, using improved research methods and tools, it should be possible to produce definitive conclusions in many of these areas.

Play Therapy Process. There are a number of conceptualizations of the therapeutic process in play therapy, such as Nordling's and Guernsey's in this issue, that are based on clinical observations and specific theoretical models. Research that has been conducted on play therapy process (Hendricks, 1971), has been constrained by small sample sizes and the research techniques of the day. Future research using larger samples and current observation systems should help illuminate common phenomena that occur at specific points of the play therapy process, independent of any particular theoretical framework.

Microskills. What constitutes an effective facilitative response in play therapy? What limitsetting techniques are most effective? These are examples of the many questions that need to be answered regarding the therapist-client interactions in play therapy. As with other areas of literature in this field, ideas about therapeutic technique are based on theoretical viewpoints. Whether or not any of the current literature on therapeutic responding and limitsetting is valid remains to be proven.

Play Therapy Training. As Cerio, Taggart, and Costa point out in this issue, training in play therapy is becoming more widespread, but the type and depth of training varies considerably. Research needs to examine such topics as training practices for different professions that counsel children (for example, school psychologists and social workers), and the type of training that prepares individuals to utilize play therapy effectively.

Multicultural Issues. Research on the use of play therapy with diverse populations of children is almost non-existent (Landreth, Homeyer, Bratton, & Kale, 1995). Future studies need to investigate such areas as cultural differences in children's play, the effects of using culture-specific toys, and differential reactions to therapist-client interactions that may be culturally based.

Physical Effects of Play. Is there a biological basis for the use of play therapy? We have known for years that exercise stimulates the release of compounds produced by the body such as endorphins, which help alleviate pain and mitigate the effects of stress (Ray & Ksir, 1990). Is it possible that play might produce similar effects with children? This may prove to be an interesting area of research to pursue, particularly during this era when many psychological disorders have been connected to brain dysfunction.

Summary

It is doubtful that play therapy, like many other forms of psychotherapy, will ever attain the stature of science. This may not even be a desired goal, for as Jerome Frank (Holland & Guerra, 1998) reminds us, a primary function of psychotherapy is to understand the *meaning* of behavior, that is, the subjective experience of the client. Thus, it may make more sense to think of play therapy as a *scientific art*. While this perspective might eschew the rigor of a physical science, it still requires empirical evidence to validate the practice of the art. It is time for researchers in play therapy to take up this challenge.

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2. Manuscripts should be typewritten, double-spaced (including references and extensive quotations) on 8½" x 11" nontranslucent white bond with 1 1/2" margins on all sides.
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“ *An era can be said to end when
its basic illusions are exhausted.* **”**

—ARTHUR MILLER

Message From the President

Jacqueline A. Bayle

Welcome to NYCA's award winning publication, *The Journal for the Professional Counselor* (JPC). It was with great pride that on behalf of NYCA, I accepted the first place award for Best Branch Journal at the 1999 ACA World Conference. Our branch also won awards for our *Action Newsletter* and Membership Services. Congratulations to all who contributed to our success.

These publications are the tools our organization uses to communicate with our members and interested colleagues. It is my goal to improve upon these existing tools and create a new publication. The *Journal* will continue to be produced twice a year, Spring and Fall, with the focus being research and in-depth articles on relevant topics to our profession. There will be some changes in our *Action Newsletter*. This will now be produced on the same schedule as our *Journal*, with Spring and Fall editions. The *Newsletter's* focus will be to present current issues, and to highlight new initiatives and innovative programs from the field. A key to the success of our *Newsletter* will be for members to share their experiences. Our new publication will be generated by the Presidential Team and the NYCA central office. It will be called, *NYCA Notes*. *NYCA Notes* will provide members with a brief monthly update on current activities of the NYCA leadership and organization. It is my hope that with this combination of communication tools, NYCA will stay in touch with its members and provide them with valuable information.

The following goals and priorities have been established for 1999-2000: (a) redefining the budget process; (b) improving the *Action Newsletter*; (c) exploring conference alternatives; (d) continuing to work towards a partnership with NYSSCA; and (e) maintaining and enhancing our relationship with the State Education Department. Our organization has been in transition in recent years. That time has allowed us to develop a solid sense of purpose and direction that will lead us into the next millennium. I look forward to your involvement in helping NYCA to grow and become the voice of the counseling profession in New York State.

Jacqueline A. Bayle is NYCA's President and a school counselor at the Philip Livingston Magnet Academy, City School District of Albany. Correspondence regarding this article may be addressed to Jacqueline A. Bayle, M.S., Ed., Philip Livingston Magnet Academy, 315 Northern Blvd., Albany, NY 12210.

“ One way or another, we all have
to find what best fosters the
flowering of our humanity in
this contemporary life, and
dedicate ourselves to that. ”

—JOSEPH CAMPBELL

From The Editor:

Observations As the *Journal* Approaches the Turn of the Century

It is an extreme honor to present you with the Fall 1999 issue of *The Journal for the Professional Counselor (JPC)*. A review of its contents will provide the reader with a stimulating look into the state of our profession as it approaches the turn of the century.

As a society, we have been repeatedly troubled by acts of violence. The first article of this issue of the *JPC* offers an illuminating depiction of youth gangs and how counselors have helped counter their destructive effects. This is followed by an article that provides a description of another type of violence, stalking behaviors, offering important implications for counselors who work with its victims to consider.

Several articles in this issue pertain to important counseling interventions. For example, an article is presented that details variables that counselors might consider in presenting student high school to college transition programs pertaining to alcohol consumption and with sexual decision making. As a counselor with over 20 years of practice experience and as a Counselor Educator, I know full-well the importance of timing as a crucial factor in facilitating client and student growth. This sometimes elusive variable is wonderfully captured in an article that frames timing as a "teachable moment."

It is no secret that counselors have become increasingly involved with the media. With the proliferation of the use of the internet we can expect this trend to increase as we move into the new millennium. In another particularly relevant *JPC* article, a variety of media strategies, advantages, and pitfalls are explored.

It is not only the college counselor who will find the article pertaining to the increased utilization of a pathology-based (DSM-IV) model in college counseling centers to be of value. As we approach the year 2000, it is apparent that the debate between those who believe in a growth and development emphasis for counselees and those who stress a pathology-based orientation has not gone away.

This issue's research article reports the results of an investigation into the differences between death and non-death grief responses among college

students. Finally, this issue concludes with a book review presented by a leader of our profession, Dr. Daniel L. Araoz.

A perusal of this issue of the *JPC* will make it evident to readers that we have continued on a course that has resulted in our having won the American Counseling Association's Best Branch Journal Award for the past two years (three times since 1996). It is my belief that we can expect the high quality of the *JPC* to continue as it is my privilege to announce that Dr. John Cerio of Alfred University has been appointed Editor-Elect. Dr. Cerio has most recently Guest Edited the Spring 1999 issue of the *Journal* that expertly covered Play Therapy. Furthermore, he has been a consistent contributor to the *JPC* and to many national counseling journals. NYCA members can be confident that the *Journal* will be in the best of hands as our profession proceeds into the 21st century.

Eugene Goldin is an assistant professor in the Department of Counseling and Development and the Editor of *The Journal for the Professional Counselor*. Correspondence regarding this article should be sent to Eugene Goldin, Ed.D., Department of Counseling and Development, Long Island University, C.W. Post Campus, Brookville, NY 11548.

Youth Gangs: A Counselor's View

Thomas M. Batsis

Jill S. Koshi

Youth gangs are a concern in communities and schools across the country. This article reviews relevant literature on youth gangs, characteristics of gang members, and measures that may help school counselors address this vexing problem. With estimates of nearly 5,000 gangs containing over a quarter of a million members in the nation, there is a pressing need to address this problem. Among other recommendations, this paper emphasizes the importance of counselors being proactive in addressing the issue of gangs in schools. The authors propose the 3A Strategy to address gang problems.

Youth gangs are a widespread, complex problem impacting large and small communities alike. Such gangs transcend ethnicity, culture, and gender. The reasons why youths join gangs are varied and complex. Once in the gang, young people become much more likely to be involved in numerous delinquent activities than non-gang members (Office of Juvenile Justice, 1997). Violent acts are much more prevalent among gang versus non-gang members, and, as a result, gang youth are much more likely to be victims of assault or to die as a consequence of gang-related activity. Hutson (1996) reports that in a one year period, gang-related violence was responsible for approximately half of all homicides in a single community. It is also important to note the increasing levels of violent crimes committed against youth, when compared to the general population (Snyder & Sickmund, 1995). Since it is such a widespread problem, it is important for counselors to examine prevention and intervention strategies targeting these youths.

An Overview of Gangs

Joe and Chesney-Lind (1995) estimate that there are approximately 4,900 gangs in the nation with 250,000 gang members. According to Harris (1994),

Youth Gangs

there are at least 600 gangs with an estimated 100,000 gang members just in Los Angeles. Contrary to popular myths and stereotypes, gang members come from varied backgrounds.

Gang Characteristics

Thornberry, Krohn, Lizotte, and Chard-Wierschem (1993) define a gang as a group that engages in deviant, disruptive, anti-social or criminal behavior. Studies have found that gang members are more likely than non-gang members to engage in criminal activity (Harris, 1994; Sheley, Zhang, Brody, & Wright 1995; Thornberry, et al., 1993). How these gangs are organized in order to carry out criminal activity varies according to each gang.

Joe (1994) defines three types of gangs, according to organizational structure. The first type is the "scavenger" gang. In this type of organization, the urban predatory group tends to be poorly organized and lacks cohesiveness. The second type is the territorial gang. In this setting there is leadership, purpose, and a turf. The third type is the "corporate gang". This type is more commercialized and has a strict set of professional codes and distinct operational roles. Although the strongest attribute of a gang is its involvement in criminal activity, there are some other general characteristics which separate gangs from being identified as just a group of youths "hanging out" together. Some of these characteristics consist of specific styles, rituals, dress, mannerisms, and social attitudes (Harris, 1994). In order to distinguish themselves from rivals, some gangs will pick a specific color, sign, and name. The name is usually derived from the area or city where they reside.

Besides coming from the same area or city, gang members tend to have very weak ties with both their families and schools. There may be lack of family support as well as feelings of belonging. These youths often drop out of school and are left with no marketable skills. Because their family ties are weak, they may experience a sense of powerlessness and hopelessness (Joe & Chesney-Lind, 1995). Joe and Chesney-Lind also note that about half of the boys and three quarters of the girls in their study reported physical abuse within the family. Furthermore, a large percentage of girls reported being sexually abused or assaulted as a young child.

Issues of Culture/Ethnicity

There are numerous ethnically-linked gangs. This is because their members try to stay loyal to their culture while attempting to assimilate into the larger culture. In the late nineteenth and early twentieth centuries, there was a rise in Irish, Polish, and Jewish gangs (Calbrese, & Noboa, 1995). Today, there is an increase in the number of gangs consisting of Asian Immigrants

(Batsis, 1996; Joe, 1994). In Hawaii, the ethnic variations of gangs are comprised of Samoan immigrants, Filipino immigrants, and Native Hawaiians (Joe & Chesney-Lind). The Island gangs, which are similar to gangs elsewhere, tend to be ethnically organized and exclusively male or female.

Female Gangs

Historically, gangs have been viewed as a male problem. However, in the barrios of Los Angeles there have been female gangs for as long as 70 years. According to Harris (1994), females tend to be more cohesive and more active than males. Reed, Moore, Miller, and Nurge (1996) identify the following characteristics of female gang members: (a) they tend to come from more troubled backgrounds than males; (b) they tend to get involved in proportionately more dangerous activities than non-gang members; and (c) the level of violence tends to be instrumental in nature. In contrast, male gang members are more likely to carry out violence for its own sake.

Reasons for Joining a Gang

There are many reasons why a child may want to be in or affiliated with a gang. One of these reasons stems from the feeling of alienation or rejection an adolescent may feel from his or her family. According to Clark (1992), in order to substitute for weak family ties, the adolescent will gravitate to those who will comfort him or her and provide a sense of belonging. To the alienated adolescent, the gang offers group support and cohesiveness. Unfortunately, this may mean turning to a deviant subculture, such as a gang (Harris, 1994).

The adolescents who have been rejected by school, work, or family will tend to have low self-esteem and may look to a group to enhance this need (Wang, 1994). A gang will offer the adolescent status and self-respect (Warr, 1996). With membership comes a sense of being valued, safety, understanding, acceptance and family (Calbrese & Noboa, 1995). It has been observed that, "Persons characterized by negative self attitudes are motivated to adopt deviant response patterns that are associated with the enhancement of self attitudes" (Wang, 1994, p. 280).

Often another group of adolescents who are looking for enhancement of self-esteem are those who have recently immigrated and are having a difficult time adjusting to a new way of life. These new arrivals often encounter a host of problems including language difficulties, parent-child conflict, and economic hardships (Joe & Chesney-Lind, 1995). In such instances, the children may feel caught between two very different value systems. On the one hand, the parents of these children have their expectations, while on the other hand, the larger society holds its own expectations (Bankston & Caldas, 1996). As a

result, the child may face issues of cultural confusion, cultural conflict, and a struggle for cultural identity (Calbrese & Noboa, 1995).

In some instances, families have been known to introduce a child into a gang as a rite of passage and as a means of maintaining cultural identity (Sheley, et al., 1995). Joe (1994) points out that the Chinese gangs of San Francisco provide a place for children to hang out and incorporate novice members into the territory by supplying them with money, weapons, and criminal opportunities. By entering into the gang, the adolescent is thought to be expressing cultural loyalty while obtaining a sense of identity, a central issue for the adolescent's development (Erikson, 1963).

Also crucial to the development of an adolescent is knowing that he or she is well protected. For example, many youths in the inner cities do not feel that they will receive this protection from their families, school or even the police (Calbrese & Noboa, 1995). This is especially true for individuals such as those with a history of violence stemming from an abusive family, a sibling who has been shot, a sister who has been raped, or who have themselves been victims of a violent crime. Given these contexts, one can understand how these individuals are likely to seek protection through gang affiliation (Harris, 1994). When the abused is a female, she may turn to the gang to learn the skills necessary to protect herself from abuse at home (Joe & Chesney-Lind, 1995). This would also be the case if an adolescent is not able to walk outside of his or her neighborhood without being threatened by a gang from another territory (Joe, 1994). According to Clark (1992), a widely known gang, the Bloods, formed for reasons of member protection.

In addition to offering protection, a gang's appeal to delinquents lies in the accessibility of drugs and the money derived from selling drugs. Adolescents without vocational training or money for entertainment, may feel that they are blocked from legitimate opportunities and, therefore, turn to illegitimate means to achieve these ends (Joe & Chesney-Lind, 1995). Some gangs have more formal, organized drug selling operations which are also more profitable and violent than other gangs (Hagendorn, 1994). The cocaine market provides opportunities for gang members to sell to neighbors, friends, and people from adjacent communities. Conversely, Hagendorn (1994) observes that some modern gangs are becoming instrumental and entrepreneurial, to the point of mirroring legal businesses.

Besides their involvement in the usage and selling of drugs, gangs are often involved in many other delinquent activities. For example, fighting is a major characteristic for which gangs have been traditionally recognized (Bankston and Caldas, 1996; Harris, 1994; Joe, 1994). These fights may be the result of territorial conflicts with another gang, challenges to test group fidelity, and to establish membership. A ritual characteristic of many gangs is the practice of

"jumping in" or "jumping out" a person from the gang. "This process involves either running a line or being in a circle where the prospective members (or ex-members) must absorb the blows of their fellow gang members to prove their worth" (Decker & Lauritsen, 1996, p. 105). Other criminal involvements of gang members include thefts, burglaries, and illicit sexual activities (i.e., Clark, 1992; Sheley, Zhang, Brody, and Wright, 1995).

Confronting the Gang Problem

Various methods counselors can use to confront the issue of gangs on school campuses and discourage gang membership will be addressed next. One suggested by Thurman, Giacomazzi, Reisig, and Mueller (1996), called suppression, involves campus sweeps of suspected gang members by law enforcement and school officials. In these cooperative efforts, local police and school administrators identify known gang members and take action to remove these youngsters from school sites. The objective of campus sweeps is to remove gang members in order to make schools safer. It requires school officials to familiarize themselves with individual gang members and put them under closer scrutiny. The goal is to deter at-risk children from engaging in gang activities. Certainly this is a laudable goal, since the presence of gangs on school property predicts the likelihood of violence on campus (Batsis, 1997).

Another form of prevention would be to work with families in the community, since one of the reasons for joining a gang is to compensate for a sense of a lack of belonging in the child's own family (Kamel, 1999). Ideally, this would help prevent alienation from occurring in the first place. According to Clark (1992), one way to encourage family support and involvement would be through establishing parenting classes, that involve teaching open communication, and the clarification of roles, and rules. Through these supportive classes, parents can enhance their children's self-esteem, along with reinforcing a sense of attachment and empowerment in their children. Recent research points to a significant correlation between increased attachment between parents and their children and lower incidents of youth violence and gang activity (Browning, Thornberry, & Porter, 1999).

Clark (1992) indicates that adolescents at all levels are at risk for gang involvement, making prevention and intervention essential. For the child or the teenager, a way to lower their level of risk would be to foster social skills, coping strategies, and adaptive problem solving. The counselor can also work to capitalize on children's strengths and provide them with an arena for success. It is also essential to find an adult who could be a positive role model for these children in order to encourage development of these skills (Wang, 1996).

Unfortunately, there are many children and adolescents who may already be involved in a gang. Nevertheless, there are still ways that they may be reached. According to Thurman, Giacomazzi, Reisig, and Mueller (1996) social workers, since the 1950's and the 1960's, have been working within neighborhoods to help gang members and at-risk youth find favorable alternatives to gang involvement. These alternatives would be temporary shelter, mentoring programs, activity centers, post-sentencing social services, drug treatment programs, and inter-gang mediation.

Thurman et al. (1996) note that there have been arguments by scholars suggesting that programs often fail when their focus is on either prevention or intervention and not both. This is because prevention programs tend to leave out those children and adolescents who have already joined a gang. Intervention strategies, on the other hand, tend to ignore those who are susceptible to active participation in gangs. As noted by Calbrese and Noboa (1995), treatment interventions could focus on providing academic or social successes to gang members and potential gang members in order to raise their self-esteem, therefore making gang membership or affiliation less advantageous.

Two specific programs have been found to involve both aspects of intervention and prevention. One program is called Youth 2020. In a newsletter published by the LaPalma, California Police Department (1996), Youth 2020 is described as being especially geared toward teenagers. This project was actually devised by a committee called YATC (Young Adult and Teen Committee), and involved teens between 7th and 10th grades. The project emphasizes youth needs as the highest priority "social goal" for the year. The newsletter identifies six areas as the focus in Youth 2020: Character Development, School Success, Lifelong Learning, Family Life and Parenting, Valuing Diversity, and Business and Employment.

Another project developed by the California Youth Authority (1993) for implementation in East Los Angeles is called the Gang Violence Reduction Project. The committee for this project consists of police officers, probation officials, and members drawn from several East Los Angeles communities. This group works at reducing gang violence by getting out into the communities and providing alternatives for youths who are both gang members and non-gang members. Some of the alternatives that are offered are job training and job placement, plus recreational and sports activities. This project is considered successful because the agency is able to involve the respected members of the communities, which in turn make the youth of the community less apprehensive about the program.

The 3-A Strategy

Counselors must frequently ask what they can do to address the problem of gang violence in schools. The authors have developed the 3A Strategy: Awareness, Assumption, and Approach. This is a comprehensive model for constructing a locally based response to the gang issue. Each component of the strategy will be addressed.

Awareness

The first and most important task for the interested counselor to achieve is the need to raise their own level of awareness regarding this issue of community gangs. One of the authors, when beginning a workshop or discussion, asks educators to name a public or private high school in the Los Angeles metropolitan area certain to contain no gang members. After a few moments of silence, respondents are informed that the only school that contains no gang members is a proposed high school that exists only as architectural drawings. Hopefully, the message to the audience is clear: every school needs to be alert to the possible presence of gang members among the student body. Thus, any school boasting the absence of gang members is probably naive and, worse still, will be caught off-guard when gang violence occurs on campus.

Educators who are willing to be open to this awareness are more likely to be prepared to adopt the succeeding steps in the overall strategy. Before leaving the first step, it is important to point out that their being open to the possible presence of gang members on campus also involves an education process that includes: (a) familiarity with known gangs in the local community; (b) understanding the dynamics of gang affiliation; and (c) law enforcement's view of the local gang situation.

In our experience, counselors often do not live in the communities where their schools are located. Therefore, they may have little understanding of the dynamic nature of a local community's life. The seeds of this understanding can begin with something as simple as a walk through the local neighborhoods, including stops to chat with community members. The senior author recalls a recent experience of visiting an inner city school that was literally the geographic intersection for four rival gangs. It would have been easy to dismiss the neighborhood as just a gang infested area. However, a walking tour with the school principal covering several blocks that included visits to local shops, chats with local community members, and lunch at a taqueria, helped drive home the administrator's point that this was a vibrant, thriving community. Thus, while there may be gang problems, there are many other positive features that helped define the neighborhood. We have found there exists a temptation to define a community in terms of its problems rather than

its strengths.

Once there is an understanding of the community, there is a need to obtain information on the type of gangs that may be present in the surrounding area. If the counselor has obtained the trust of community members, they will freely share their impressions of the gangs. However, the counselor must be someone who is viewed as trustworthy and the task of building this trust may take time. After years of their being on the receiving end of bureaucratic bungling, the suspicions of community members are easy to understand.

In addition, informal discussions with students about gang problems often prove to be time well spent. Making it clear to students that you want only to understand the issue will frequently result in students offering valuable information. Describing yourself as a student who is there to learn is a strategy that may pay huge benefits.

The second task faced by the counselor is to understand the dynamics of gang affiliation. While we have discussed this point in a previous section, it is also important to emphasize that there is no ubiquitous reason for gang membership. There is an abundance of literature on the dynamics of gang affiliation, and familiarity with this body of work can certainly be helpful to the counselor. On the other hand, the counselor needs to seek the answer to the question, "Why do youngsters in this community join gangs?" While the answer(s) to this question may only serve to reinforce what the literature has suggested, to accept a literature-based response to this question may to be overlook the unique characteristics of a particular community.

Finally, there is the question of law enforcement's view of the gang issue. Police officers are in constant contact with the community, especially with the criminal segment, and can offer valuable insights regarding the presence, number, and structure of gangs in the area. Therefore, it is especially important to ask them about gang names, styles of dress (colors), graffiti markings (tags), and types of criminal activities. However, it is equally important that counselors maintain a perspective when discussing gangs with law enforcement. Police officers deal with gang members in a manner quite different from the way in which a counselor will interact with a student who has gang affiliation. The counselor is not a police officer, and law enforcement is best left with that governmental agency. The counselor's role is to help youngsters confront and understand their behaviors, and, hopefully, be motivated to change.

Assumptions

After completing the Awareness stage, the counselor is prepared to move to the second step in the 3A Program, "Assumptions". Assumptions are so

much a part of the every day human experience that we are frequently unaware of the powerful influence they have over our behaviors. The benefits of assumptions are that they allow us to short-circuit problem solving activities and move more quickly to solutions. On the other hand, assumptions can also be the genesis for the categorization of groups, if not outright prejudice. The news media, particularly locally televised news programs, will at times show graphic details of gang violence that create the impression that gang members pose a direct, imminent threat to everyone. The facts are that the overwhelming percentage of gang violence is directed at gang members (Chin, 1996). At the same time, we also need to acknowledge that gang violence has a very negative impact on the overall school climate.

In examining his or her assumption of threat, the counselor is advised to see the youngster who is gang affiliated as someone who is struggling with many of the same problems and issues as many other students in the school. This is not to suggest that the counselor ignore the issue of gang membership, but rather that he or she endeavor to see all teenagers as individuals; in other words to grant this client the same right to being viewed as a unique person as would be accorded to any other student who approached the counselor for assistance. This is consistent with Clark (1992) who recommends that the counselor consider the whole person rather than just focus on their gang membership.

Approach

Having worked through the first two segments in the strategy, the counselor is now ready for the final step, "Approach". Because of preconceived notions about gang members, it may be difficult to approach and to begin talking with a gang member in the school. It is very likely that the counselor has already been talking to gang members in the school, without even being aware that a student is a gang member. Furthermore, it is important to remember that among the reasons we listed earlier for youngsters to join gangs is the need for affiliation. Gang members have frequently felt alienated and cut-off from others. The gang gives a sense of belonging. Acknowledging this need to connect, the counselor, will tend to succeed in expressing the person's importance.

Frequently, counselors may provide a valuable service in just providing a therapeutic sounding board for a client. Counselors may wonder, what did we do? What we did was listen and acknowledge the value of the client just by being present to them. In approaching, listening, and talking to the youngster, not as a gang member, not as a member of some group, but as a human being, we affirmed the person's worth.

The "Approach Strategy" may require a variety of techniques and forums to develop an on-going dialogue. There may be a need for informal discussion in hallways, in lunchrooms, and in the school yard. It may be a one-on-one chat or a small-group discussion. It is important to keep in mind cultural variables that may help suggest effective strategies for these encounters (Leung, 1995). A great deal of time may be spent developing trust by discussing seemingly irrelevant topics. However, if the counselor remembers that the goal is to make a connection, this will not be wasted time.

Conclusion

In this paper we have discussed the many variables leading to gang membership. We have noted the difficulty posed when gangs make their presence known on a school campus, particularly the increased potential for serious violence. The role of the school counselor in addressing the gang issue was discussed, with emphasis placed on defining the counselor's role in working with potential and gang-affiliated students. We recommended the adoption of a 3-A strategy for addressing the gang issue. While this strategy will usually not offer immediate results, the long-term outcomes may go far in helping to reduce gang-related tensions on school campuses.

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“ *Poetry is the opening and
closing of a door, leaving those
who look through to guess
about what is seen during a
moment.* ”

—CARL SANDBERG

Stalking Behavior: Love and Delusion

David Farrugia

The major types of "love" motivated stalking behavior are discussed. One type of love motivated stalking is generally associated with celebrity stalking. This form of stalking is characterized by the stalker seeking to impress the victim with the stalker's love. A similar type of stalking is erotomania where there is an obsessional fixation with a love object and belief that there is an intimate relationship where no actual love relationship has occurred. Another form of stalking behavior discussed is a form of domestic abuse that may continue after the end of an intimate relationship. Descriptions of the respective characteristics and dynamics of these forms of stalking are provided. Treatment principles used in counseling are also discussed.

Introduction

When people experience obsessive forms of behavior motivated by infatuation or "love", it can be a frightening and even terrifying ordeal (Mullen and Pathe, 1994b; Leong, 1994; Hall, 1997). Most counselors are familiar with a number of cases that have received national attention including the Tarasoff case (Winslade & Ross, 1983) which is the legal foundation of the counselor's duty to warn intended victims of the potential for harm. Tatiana Tarasoff was the target of obsessive stalking behavior by Prosenjit Podder, a graduate student in electronics and naval architecture, before Podder shot and stabbed Tarasoff to death. Over the course of what seemed to be a relationship of friendship, Podder became obsessed with Tarasoff. In the Fall of 1968, Podder and Tarasoff met through a weekly folk dance group. They danced together and talked on the phone and even privately in his college dorm room (Winslade & Ross, 1983). Podder had romantic interests in Tarasoff and thought about their relationship as a love relationship. Tarasoff did not share his perception about their association. Podder recorded approximately 40 hours of their conversations and frequently listened to the

recordings. He became increasingly obsessed with Tarasoff. His behavior and performance in school was affected. His speech became disjointed and he displayed emotional behavior characterized by weeping (Lipson & Mills, 1997). Podder withdrew from his courses at the University of California at Berkeley. In March of 1969 Podder asked Tarasoff to marry him. Tatiana did not say yes to Podder's proposal, but apparently she did not clearly turn down the marriage proposal (Winslade & Ross, 1983). During the Spring of 1969 Podder began to believe that Tarasoff's friends were laughing at him.

He also began to voice threats to others about his intentions toward Tarasoff. Podder did seek counseling help during the Summer of 1969. Podder also became friends with Tarasoff's brother and in September they moved into an apartment together. Podder hoped that eventually Tatiana would share the apartment with him. He also developed a fantasy that he would rescue her from a life threatening situation and then she would recognize and respond to his love for her. In the Fall of 1969, he threatened to kill her to a friend and later to his therapist (Leong, 1994; Franzini & Grossberg, 1995). Podder's behavior in counseling led his therapist to contact the police and recommend that Podder be confined. Podder was eventually contacted by campus police and denied threatening Tarasoff, but instead indicated that he and Tarasoff had a troubled relationship. Tarasoff was never informed of the therapist's belief that she was in danger. On October 27, 1969, he went to her home with a pellet gun and a knife. She insisted he leave, but he did not. He shot her and stabbed her 14 times (Lipson & Mills, 1997).

Other high profile cases that have been discussed in the media include David Letterman, Jodie Foster, Madonna, Whitney Houston, Kathie Lee Gifford, Michael J. Fox and Janet Jackson (Orion, 1997). Letterman was stalked by Margaret Ray for a number of years. While Letterman was out of town, Ray moved into his house in Connecticut with her three year old son and drove Letterman's car introducing herself to people as Mrs. Letterman and her son as Dave Jr. Even after repeated arrests and treatment in a mental health facility she returned to his property a number of times (Perez, 1993).

When John Hinkley Jr. shot President Ronald Reagan in 1981, he was trying to get the attention of the actress Jodie Foster. He had followed Foster before the shooting and had written her numerous letters indicating his love for her. Hinkley even slipped some notes under the door of her dorm room while Ms. Foster was at College (Perez, 1993).

Although celebrity cases receive national attention, victims of stalking behavior come from all social and vocational walks of life. According to Kurt (1995), stalking as a form of domestic violence is far more common than celebrity or stranger stalking. Mullen and Pathe (1994b) note that victims of erotomanic attachment were selected from people encountered at work, from

those who provided a service to the stalker such as medical or legal work or even from people who were met socially. They noted that teachers, counselors and health care workers were targeted. Leong (1994) stated that people in the helping professions may be of particular risk. Orion (1997), a female psychiatrist, described her experience of being stalked by a former female client for over eight years. Orion's experience with the legal system and with the mental health system, of which she is a part, vividly illustrates the lack of knowledge and appropriate procedure that currently exist in the helping and service professions.

Perez (1993) estimated that over 200,000 people in the United States exhibit stalking behaviors and come from all economic levels. Cases of obsessional fixations of love comprise approximately 3% of in-patient diagnoses according to Retterstol and Opjordsmoen (1991). Approximately 10% of delusional disorders have components of love oriented delusions (Rudden, Sweeney, & Frances 1983). Dietz (1988) and Mullen and Pathe (1994b) believe that the problem is more prevalent than generally perceived. The purpose of this article is to examine the central forms of stalking behavior and to suggest treatment considerations for the counselor who works with a stalker or the victim of a stalker.

Understanding Stalking Behavior

Love Obsessional Stalking and Erotomania

Obsessive behavior motivated by infatuation or love can be manifest in a number of forms. Zona, Palarea & Lane (1997) have developed a typology of stalkers that include "simple obsessional stalkers", "love obsessional stalkers" and "erotomantic stalkers". The simple obsessional classification describes stalkers who have been in an intimate relationship with the victim and are motivated to coerce the victim back into the relationship or to seek revenge for the break-up of the relationship. The love obsessional stalker has never been in a relationship with the victim, and stalks the object of attraction in order to impress the victim with the stalker's "love". This type of stalker is often associated with celebrity stalking, although ordinary citizens are also sometimes targeted by this type of stalker. Similar to the love obsessional stalker, the erotomantic stalker has never had a relationship with the victim. However, unlike the love obsessional stalker, the erotomantic stalker delusionally believes that he or she is loved by the victim. Mullen and Pathe (1994a) view stalking behavior on a continuum. At one end are behaviors that show excessive and exuberant manifestations of love and at the other end of the continuum are clear delusional states. By considering stalking behaviors

from this perspective, obsessive thought patterns and excessive behaviors can be considered pathological extensions of normal love behaviors. For example, behaviors associated with common forms of jealousy are extended and magnified in the fixations evident in stalking. Mullen and Pathe (1994a) find it useful to identify the roots of stalking behavior in general love attachment; however, as behavior on the continuum becomes more excessive and delusional, it also becomes more pathological and sometimes dangerous.

Robert Hoskin's stalking of the pop singer Madonna illustrates the love obsessional type of stalker described by Zona, Palarea and Lane (1997). In 1995, Hoskins went to Madonna's home several times (Saunders, 1997). He scaled the wall around her house and was ordered off the property by Madonna's bodyguard and by her personal assistant on different occasions. He told the bodyguard that he would slice Madonna's throat from ear to ear if she did not marry him. Seven weeks later Hoskins returned to Madonna's property and again scaled the wall around the house. He was stopped by her bodyguard and in a struggle took the bodyguard's holstered gun. The bodyguard was able to regain control of the gun and Hoskins was shot twice in the abdomen. Hoskins was later found guilty of stalking, terrorist threats and assault. While awaiting sentencing, he wrote graffiti on the walls of his cell which read, "I Love Madonna" and "Madonna Love Me" (Saunders, 1997, p. 41). Madonna reported experiencing both anxiety and nightmares due to Hoskins' behavior.

The French psychiatrist, de Clerambault, is widely recognized as the first to clearly describe erotomania from a psychiatric perspective in the 1920s (Signer, 1991). Criteria for the diagnosis of erotomania that have evolved from de Clerambault's work are reflected in the Diagnostic and Statistical Manual of Mental Disorders IV (American Psychiatric Association, 1994) under the category of delusional disorder of the erotomanic type. Five criteria appear in the DSM IV (1994) and are listed below:

1. the presence of non-bizarre delusions (that is, situations that could occur in real life) of at least 1 month's duration in which the predominate theme of the delusion(s) is that a person usually of higher status, is in love with the subject,
2. auditory or visual hallucinations if present are not predominant,
3. apart from the delusion(s) or its ramifications, behavior is not obviously odd or bizarre,
4. if a major depression or manic syndrome has been present during the delusional disturbance, the total duration of all episodes of the mood syndrome has been brief relative to the total duration of the delusional disorder; and

5. the individual has never met criterion A for schizophrenia, and it cannot be established that an organic factor initiated or maintained the disturbance. (p. 153)

Although de Clerambault's syndrome was originally limited to women of "lower social standing" who had little sexual experience and who fixated on older men of "higher social standing" (Giannini, Slaby, and Robb, 1991), it is now widely recognized that the disorder occurs in men and women (Dietz, 1988, Zona, Palarea & Lane 1997). Giannini, Slaby, and Robb (1991) also found that women who had extensive sexual experience developed the disorder. The women in their case examples were both heterosexual and homosexual. Giannini, Slaby, and Robb (1991) indicated it was no longer appropriate to consider the disorder primarily a disorder of chaste heterosexual women. Peterson and Davis (1985) and Dunlop (1988) also reported homosexual and heterosexual cases of erotomania in male and female populations.

Regardless of the target or the sex of the perpetrator, behaviors associated with erotomania often include telephoning the target, following the target, and declaring to others that there is a romantic involvement. In some cases the behavior of the stalker may escalate to threats directed at the victim, destroying property of the victim and even violence directed at the victim or a person close to the victim who is perceived to be an obstacle to the erotomaniac perpetrator (Leong, 1994; Harmon, Rosner, and Owens, 1995). In some cases the perpetrator will take extreme measures in pursuit of the object of the fixation.

Franzini and Grossberg (1995) describe the case of Diane Schaefer, a freelance medical writer and exotic dancer who pursued Dr. Murray Brennan, a cancer surgeon, for over eight years. She frequently arranged for adjoining hotel rooms or plane seats when Dr. Brennan went to professional seminars. She contacted his office using various aliases and disguised voices. She left obscene messages on his answering machine and wrote numerous letters to his family. Upon her arrest she maintained her belief that she and Dr. Brennan were former lovers. During her trial, her attention and stalking behavior shifted to the assistant district attorney and even to the trial judge.

Erotomania can be considered as a primary diagnosis or as a secondary diagnosis. Meloy (1989) states that a personality disorder often accompanies erotomaniac symptoms. Erotomania and other forms of stalking are often seen in conjunction with psychoses, the most usual being schizophrenia (Ellis & Mellsop, 1985; Leong, 1994; and Harmon, Rosner and Owens, 1995). It is also possible for the erotomaniac to switch a fixation onto another with whom they have contact and then target (Mullen and Pathe, 1994a).

Stalking as a Continuation of Abuse in a Relationship

Stalking behavior when the stalker has or did have a relationship with the object of the behavior is different from the erotomaniac or love obsession forms of stalking (Segal, 1989; Zona, Palarera & Lane, 1997). Zona, Palarera, and Lane have called this type of behavior simple obsessional stalking. Kurt (1995) considers it a form of domestic abuse. Stalking as a variant of domestic abuse has similar manifestations as stalking based on love obsession, however, the target is not just an object in fantasy. The object is pursued by the stalker over the phone, in person and in a manner that may include threat, damage to property and violence (Kurt, 1995). Common wisdom suggests that stalking behavior occurs generally after a separation in a relationship or upon the threat of separation. Motivation for stalking behavior includes jealousy, rage at rejection, revenge and sometimes in cases of lethal violence, a desire for unification in death (Mullen and Pathe, 1994b; Harmon, Rosner, and Owens, 1995). Hamberger and Hastings (1986) report that the majority of men who batter as a component of stalking behavior meet the DSM IV criteria for personality disorders. Goldstein (1987), Taylor, Mahendra & Gunn (1983) and Meloy (1989) note that stalking behavior by males is more likely to result in violent acting out than in female cases of stalking. The most likely group of stalkers to be violent are the simple obsessional type who have had a prior intimate relationship with the victim (Meloy, 1997). Frequency of violence toward the victim in this group is estimated between 25% and 35%. Although violence is possible in erotomania, Dietz (1988) found that fewer than 5% of erotomaniac individuals are violent.

The case of O.J. Simpson and the death of Nicole Brown and Ron Goldman illustrate stalking as a variant of domestic violence. On several occasions during their marriage, Nicole Brown was hit by Simpson (Walker and Meloy, 1997). For several months after they separated, Simpson engaged in a variety of stalking behaviors including making numerous phone calls, leaving gifts on Brown's doorstep, frequenting neighborhood restaurants in the hope of meeting her and even hanging around her house and looking through her windows at night.

Stalking behavior related to domestic abuse puts the targeted person and potentially his or her protectors at risk. It is not easy to predict when stalking behavior may become violent. Harmon, Rosner, and Owens (1995) studied 48 forensic cases of harassment related to stalking and found that there was a relationship between defendants who had threatened violence and then subsequently were violent. In most cases the violence was directed at the object of the obsession. In a minority of their cases, 3 of 48, violence was directed at the victim without prior threat.

A particular problem with stalkers is the observation that many ignore

orders of protection and other legal sanctions in pursuit of their fixation. In the study done by Harmon, Rosner, and Owens (1995) of convicted stalkers, 46% violated orders of protection. Another indicator of the persistence of some stalkers is the high rate of recidivism among this population. Harmon, Rosner, and Owens (1995) found a 46% recidivism rate in their study. Segal (1989) and Dietz (1988) also report a high rate of recidivism. In cases of stalking following romantic involvement and in cases of stalking as a result of the obsessional forms of stalking, repeated stalking behaviors are usually directed at the victim. Victims may indeed be stalked for many years (Perez, 1993; Orion, 1997).

Intervention Strategies

Dealing with stalking behavior in a clinical context requires the counselor to have an understanding of legal strategies in addition to the core skills of counseling. When working with victims of stalking behavior, the counselor should encourage the client to involve legal authorities and sanctions at the early stages of an experience with a stalker (Franzini & Grossberg, 1995). Even though many stalkers ignore restraining orders, it is useful to have a restraining order in place as a foundation from which to act should the stalking behavior begin to escalate toward violent behavior (Harmon, Rosner & Owens, 1995; Kurt 1995). The Interstate Stalking Punishment and Prevention Act of 1996 makes it a federal crime to cross state lines to injure or harass another person. It also makes a restraining order issued in one state enforceable in another state (Saunders, 1997).

Since 1990 all 50 states have addressed the problem of stalking by developing new statutes or revising existing statutes to apply to stalking (Kurt, 1995). Most state statutes originally defined stalking behavior to include a credible threat, either expressed or implied (Kurt, 1995). The concept of "credible threat toward bodily injury or death" has acted to limit the application of the law. A number of states have amended stalking laws to include the National Institute of Justice recommendation that annoying or emotionally distressing conduct be added to the law (Perez, 1993). This kind of language allows stalking behavior that does not imply a clear threat to be punishable. In order to determine the wording of the stalking law in a specific state, counselors would need to check their state penal code.

Little information is available that directly addresses the treatment of the victim of stalking behavior, however, treatment models for domestic abuse victims have been applied to stalking (Walker & Meloy, 1998). Support and validation of the client's experience is a fundamental part of the therapy. Since the harassing behaviors of stalking are experienced as a psychological threat

to the victim, Walker, (1994) believes that it is important for the victim to verbalize how she has been affected by the experience. Sometimes the victim may have difficulty recognizing just how abnormal the stalking behavior has been, especially if the client has been involved in a long term abusive relationship with the stalker. It is not uncommon for victims of stalking to exhibit symptoms of Post Traumatic Stress Disorder (Orion, 1997). Early in the counseling process, the counselor should work with the client to develop a safety plan (Walker, 1994). A safety plan is a concrete plan that identifies escape routes, police contacts and other support contacts. The plan is written out by the client and verbally rehearsed while considering hypothetical future situations that could escalate into violence.

Due to the persistence of some stalkers and the often inadequate response of the legal system, Orion (1997) recommends that the victim be encouraged to take responsibility for his or her response to the stalker. She recommends that the victim be encouraged to contact victim support groups such as Survivors of Stalking located in Tampa, Florida or the Threat Management Unit in Los Angeles, California. In addition, she recommends that the counselor and the victim recognize the limitations of the legal system when dealing with stalkers. A persistent stalker will often ignore restraining orders and other attempts to limit access to the victim.

Orion (1997) indicates that the victim of stalking may have to deal with the tendency of police and friends to minimize the plight and distress of the victim. She recognizes a tendency for many people including some police personnel to downplay the potential for violence in stalking situations. She states that people may suspect that the victim must have done something to encourage the stalker's behavior. Orion also warns therapists that the fundamental counseling skills used in developing a helping relationship may encourage the erotomanic stalker to fixate on the therapist. However unintended, the client may interpret clinical compassion and caring as evidence of love.

Unfortunately, attempts to isolate the victim from a persistent stalker often fail. Perez (1993) and Franzini and Grossberg (1995) note that removing addresses and phone numbers from local listings is usually not an effective means to deter stalkers. Perez (1993) and Franzini and Grossberg (1995) describe a variety of measures to use with a persistent stalker including notifying the police and securing a restraining order as a first step. The person who is stalked is also encouraged to keep a diary of the experience and to try to obtain a direct contact with one specific police representative. Other measures include installing property security systems, avoiding being alone, keeping addresses and schedules private, having others screen mail and phone calls, and checking with co-workers on a regular basis to determine if there has been any inappropriate contact or inquiry at the place of employment.

In extreme cases of threat the victim might consider putting property into others names, consider the use of a bodyguard and even consider moving to a new location.

Although there are not well developed protocols for treatment of stalkers, Mullen and Pathe (1994b) believe that treatment of most stalkers has a relatively positive prognosis. Since the behavior of most stalkers fit the criteria for underlying disorders, it is important for counselors to recognize the indicators of manic disorders, personality disorders or schizophrenic disorders. When these underlying disorders are identified, appropriate medications, counseling support and rehabilitation programs should be utilized that fit the intrinsic disorder. Due to the nature of schizophrenia, Mullen and Pathe (1994a) state that the stalker with a schizophrenic disorder will be the most difficult to treat. A number of writers suggest that some clients will persist for months or even years with the same obsessional fixation, while some erotomaniacs will switch their fixation to other objects as time progresses (Kurt, 1995; Mullen & Pathe, 1994a).

Mullen and Pathe (1994a) state that the use of antipsychotic medication coupled with a supportive yet challenging therapy is the best strategy for ameliorating the delusional thought patterns associated with stalkers. They caution that during the acute stages of morbid fixation that confrontation is usually unproductive. Orion (1997) recommends the idea of group treatment utilizing a recovery model to treat stalkers.

Summary

Although the literature is not extensive regarding the treatment and strategies counselors should consider when dealing with stalkers, the counselor is encouraged to keep in mind the following principles as previously described in this article:

1. Validate and support the target of stalking behavior.
2. Assist the victim of stalking behavior to develop a safety plan.
3. Direct the client to contact police authorities in order to utilize appropriate legal protective statutes.
4. Provide the client with information to contact organizations that provide information to victims.
5. Recognize that although the majority of stalkers do not become violent, the object of the fixation as well as those who stand in the way of the stalker including the counselor, may be at risk.
6. Recognize that stalking behavior emerges from different dynamics

including obsessional love directed at a person in a former relationship, or in cases of erotomania, toward a person where no relationship ever existed.

7. Recognize that underlying psychiatric conditions are usually part of the stalker's psychology and must be treated appropriately.

Although the counselor will be better able to assist clients who face this unnerving experience by understanding the dynamics of stalking behavior, and recognizing the preceding principles for dealing with stalking behavior, there are several issues related to stalking that warrant additional research in order to provide better insight and direction for counselors who work with the consequences of stalking. Better guidelines to assess the seriousness of threat to victims is needed. Better treatment protocols to assist victims as well as stalkers is needed. In addition, better education of the public as well as the law enforcement community on the seriousness of stalking behavior is needed.

Living in fear of a stalker can be a difficult ordeal. Although our cumulative knowledge of this unique experience continues to advance, counselors who understand the variant dynamics associated with stalking and the treatment principles implied by each stalking circumstance are in the best position to help victims of stalking.

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“ *A happy person is not a person
in a certain set of
circumstances, but rather a
person with a certain set of
attitudes.* ”

—HUGH DOWNS

School to College Transition Programs: Straight Talk About Alcohol and Sex

Joan M. Gibson

The interpersonal component of school to college transition programs is discussed, focusing on the importance of including alcohol abuse and sexual assault information. Suggestions for possible program development and intervention strategies are given to assist school counselors in their role as human relations and development specialists.

The time of transition to college is often a tenuous one. Academic, developmental, social, and emotional concerns all need to be addressed effectively to prepare students for the many changes college will bring. While academic skills, good study habits, and attending classes are all necessary components for success at college, "the student peer culture frequently does not support these efforts" (Warner, 1998, p. 3).

The U.S. Department of Education (1992) reported that only one-half of students enrolled as full-time freshmen completed a bachelor's degree at the same institution within six years. Colleges have recognized the need to implement transition and/or retention programs. Nearly two-thirds of all colleges have basic, semester-long seminars that help first-year students adjust to college (Gose, 1995). Many of these seminars provide basic information about campus resources and give suggestions about ways to adapt to the college environment. The goal of these programs is to fortify and support the student's attainment of academic and personal goals (Geraghty, 1996).

Many high schools attempt to give their graduates a better chance for success in the transition to college by providing juniors and seniors with college preparatory skills and knowledge to assure that students are academically and developmentally prepared to make a successful transition to col-

lege. Some of these programs include a personal component in addition to academic preparation. The area of personal goals appears to be a crucial one in which students develop a personal identity and develop an integrated philosophy of life (Upcraft and Gardner, 1989). Interpersonal issues like "Personal Safety" and "Accepting Responsibility for Personal Actions" can be found in many transition programs such as The College Transition Course (State University of New York, 1997), piloted from 1993-1997 as a high school senior-year college preparatory course.

It is the belief of this author that the social issues encountered on a college campus may very challenging for many students. Alcohol consumption and sexual relationships, for example, are two components of the social domain that students need to successfully navigate.

School counselors might be in the best position to prepare college-bound students to survive the social pressures of college. The American School Counselors Association (ASCA) included in its role statement for school counselors the task of "developing and presenting special guidance units which give attention to particular developmental issues or areas of concern in their respective schools" (American School Counselors Association, 1990). The *National Standards for School Counseling Programs* (American School Counselors Association, 1997) further emphasizes that programs focusing on personal and social development are the essential elements of an effective school counseling program.

The purpose of this article is to provide information and suggest strategies to support the interpersonal segment of these high school to college transition programs regarding alcohol consumption and acquaintance rape. The information and strategies complement the ASCA program standards to provide the "foundation for personal and social growth as students progress through school and into adulthood" (American School Counselors Association, 1997, p.17).

Alcohol Consumption

The use of alcohol and other drugs is already a significant part of many adolescents' high school experience (Scott, 1996). In the United States, surveys of adolescent drinking consistently find that the majority of teenagers have consumed alcohol. Evans and Bosworth (1998) found that 90% of high school graduates have tried alcohol and 33% have been recent heavy drinkers. Once a student is at college, involvement with alcohol has consistently been associated with missed classes, poor performance on tests and projects, academic underachievement, and unsafe sexual behaviors (Hanson & Engs, 1992; Presley, Meilman, & Lyerla, 1993; Wechsler & Isaac, 1992). Since there

is a significant correlation between the age of first use and the development of subsequent alcohol-related problems (Prendergast, 1994), high school counselors should be alert to any college-bound student having a tendency to abuse alcohol or other drugs.

Another strong factor influencing an incoming college student's level of drinking is the perception of drinking norms on campuses (Haines, 1997). Haines found significant discrepancies between the actual levels of alcohol consumption among college students and the students' perceptions of their peers' usual drinking levels. Students consistently overestimated both the amount of alcohol other students routinely consumed and the number of students who drink. Haines concluded that students will try to emulate, in their own drinking, the campus norms they perceive.

How might counselors work with high school students to challenge their misperceptions of alcohol use at college? One way is with facts. A survey of 252,000 college freshmen, conducted in 1997 by the Higher Education Research Institute at the University of California at Los Angeles, indicates "53% of freshmen said they drank beer frequently or occasionally, down from 72% in 1981" (Gose, 1998, p. A37). That's a decline in drinking of nearly 20% in 16 years. It may also surprise some high school students that the majority of college students report drinking little or no alcohol on an average weekly basis (Meilman, Presley, & Cashin, 1997).

Counselors might borrow some of the strategies developed by Haines and Spear (1996) who utilized the campus norm approach at Northern Illinois University. They displayed "college drinking facts versus myths" advertisements in the campus daily newspaper, flyers at student events, pamphlets, and informational tables in the student union and residence halls. After implementing their campaign, students' perception of the degree of campus drinking had dropped by more than a third from that recorded six years earlier. This process of altering the perceived norm for college drinking could certainly begin in school to college transition programs.

Acquaintance Rape

Acquaintance rape has been defined as nonconsensual intercourse between two individuals who know each other (Parrot & Bechhofer, 1991). Acquaintance rape is unfortunately very common on college campuses. The latest data from *The Chronicle of Higher Education's* annual survey of crime at nearly 500 of the country's biggest colleges and universities show a 61% increase in forcible sex offenses from 1995 to 1996 (Lively, 1998). Finley and Corty (1993) found that 36% of first-year female students reported nonconsensual intercourse. Consistent with this finding, Himelein, Vogel

and Wachwiak (1994) found 38% of college women reported a sexual assault with an overwhelming proportion of those assaults committed by someone with whom the victim was acquainted. Acquaintance rape is not a female-only threat. Male rape, although not reported as frequently as female rape, can occur as well on campuses. Male victims are often too embarrassed and humiliated to admit that they were overpowered or made helpless by another person (Scarce, 1997).

The aforementioned information is important to those delivering a college preparation program because a significant proportion of students who are victims of campus sexual assaults do not remain at the institution where the assault took place, transferring or dropping out altogether (Bohmer & Parrot, 1993). Furthermore, these assaults happen most often during the woman's first year of college, and in particular, "during the first months on campus, before they know the social rules" (Bohmer & Parrot, 1993, p. 26). It may be that information about personal safety, skills for clearly communicating intentions, and respecting another's limits may be most effectively taught prior to a student's arrival on campus.

Due to the increasing incidence of rape within the adolescent population, many school counseling departments have already developed school-based strategies (Becky & Farren, 1997; Fay & Flerchinger, 1993; Simon & Harris, 1993). These rape prevention programs could easily be expanded to include information particular to college-bound students. A residential college campus, for example, incubates the conditions for acquaintance rape. Fraternity houses are listed as one of the most common locations for sexual assaults (Copenhaver & Grauerholz, 1991). The presence of an active Greek system, as well as the existence of campus dormitories, can drive sexual assault numbers up because they are natural places to hold unsupervised parties (Lively, 1998). Tactics such as asserting that "everybody does it" or questioning the woman's sexuality exert sufficient peer pressure on the incoming undergraduate student who is attempting to integrate into a new social group and find acceptance among peers. Wanting to "fit in" sometimes can make young women vulnerable to verbal sexual coercion, especially when exacerbated by alcohol consumption. Misunderstandings and conflicts may also develop as young men and women make assumptions about the other person's behavior.

The belief that alcohol is an aphrodisiac and sexual disinhibitor appears throughout recorded history. Alcohol, in reality, decreases the woman's ability to resist sexual advances and disinhibits the man's aggressive behavior. It is no surprise, then, that one of the greatest contributing factors to acquaintance rape is the use of alcohol (Parrot, 1991). In nearly all of the literature on acquaintance rape, alcohol consumption by one or both parties is linked to the incident. In particular, for both male and female high school

students, the strongest predictor of sexual activity is alcohol consumption (Harvey & Spigner, 1995). In another study with high school students, 50 % of teen pregnancies were found to be alcohol-related (Simon & Harris, 1993).

Practical Implications

If the transition from high to college can be negotiated successfully, the likelihood of student retention is greatly increased (Terenzini et al., 1994). Easing the passage into the social realm of a college setting might be one way in which the high school counselor can contribute to this success. What would it look like for a school to college transition program to include knowledge of drinking myths and of the strong relationship that exists between alcohol use and acquaintance rape on college campuses?

Because the most frequent kind of rape incident to occur on a college campus involves acquaintances (Parrot & Bechhofer, 1991), many of the typical strategies employed by colleges to create a safer campus environment do not adequately address this issue (Wiehe & Richards, 1995). Tightened security in residence halls, increased number of campus police, utilization of emergency telephones, and escort services are all worthwhile and necessary strategies to maintain a safe campus. However, they may have an insignificant effect when attempting to address acquaintance rapes that occur in a residence hall, apartment, or home.

School to college transition programs need to focus not only on personal safety issues when outside one's residence, but focus prevention efforts at the personal level. Young women should learn about "high-risk situations that may lead to acquaintance rape" and young men should learn to "assume responsibility for their behavior in interpersonal relationships with women" (Wiehe & Richards, 1995, p. 154).

Group educational efforts toward prevention of acquaintance rape may be initiated as early as junior high school when students are beginning to date because early teens have considerable misinformation about rape (Kershner, 1996, Wiehe & Richards, 1995). Curriculum topics should include training in social skills related to sexual negotiation, perceived harm, protective factors, and refusal skills (Evans & Bosworth, 1998). These topics reflect the content area of Personal/Social Development of the ASCA National Standards that states, "Students will acquire the attitudes, knowledge, and interpersonal skills to help them understand and respect self and others" (American School Counselor Association, 1997, p. 17).

Successful programs about acquaintance rape focus on risk reduction for females and on the attitudes and behaviors that make males potential perpetrators (Berkowitz, 1994; Funk, 1993; Keeling, 1998). High school males

should be educated about the psychological and social effects of the culture of masculinity that encourages them to take risks, be sexual conquerors, and never take "no" for an answer. Many young men need to be taught non-violent methods of handling anger as well as how to behave respectfully within a relationship (Bohmer & Parrot, 1993). Programs for "Young Men Only" are appropriate for these discussions and should be lead by respected adult males or male and female co-leaders.

Perhaps the greatest contribution educators can make in preventing sexual abuse is modeling respectful and equitable behavior in all their relationships. Rosenbluth, the coordinator of Austin's Teen Dating Violence Program (as cited in Harrison, 1997), believes that young men need role models like male coaches, principals, and teachers who "demonstrate the full range of masculine traits and don't just reinforce the ones associated with power and control" (p. 43).

Coaches and trainers of the high school athletic teams can be exceptional models in teaching discipline, self-restraint, and moderation. High school team members already abide by a "no alcohol" policy. Ironically, college athletes are among the largest consumers of alcohol and are one and a half times as likely to be binge drinkers as are other students (Leichliter, Meilman, Presley, & Cashin, 1998; Wechsler, 1998). School counselors should consult with their colleagues in the athletic department and engage them in the challenge of this programming.

Haines and Spears' (1996) found that the student school newspaper can be used to help shape a more realistic perception of campus environments by not promoting the fantasies of alcohol-related activities. Furthermore, they found that stories covering alumni's first-year experiences at various 2-year and 4-year colleges could have a positive impact on college-bound students. They observed that stories containing factual information about student life at college can support a more realistic expectation of what lies ahead.

School to college transition programs can target college-bound students and encourage early conversations about expectations regarding both sexual behavior and drinking practices. Talks and honest dialogue with handpicked alumni returning for homecoming week may help minimize the "rites of passage" attitudes of college-bound students. High school students are more likely to believe the messages of college students than those of counselors, teachers, and other adults are. As Wechsler (1998) concluded, "Let future freshman get their first view of college life from these volunteers, rather than from attending fraternity parties.... Once freshmen have unpacked and settled in, it may be too late to tell them about college rules on alcohol use" (p. B4).

This article has attempted to bring into focus two of the realities of the college experience - alcohol abuse and acquaintance rape. Given accurate information and data, the hope is that school counselors will be enabled to create effective college transition programs that prepare high school students to deal with the complex new social scene of a college campus.

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“ *We must not allow other
people's limited perceptions
to define us.* **”**

—VIRGINIA SATIR

Capturing the Teachable Moment in Counseling

Beverly B. Kahn

Guidelines for using teachable moments in counseling are explored. The necessary elements of a teachable moment are examined throughout the counseling process. The techniques of counselor modeling, reframing and metaphor are defined as teachable moments with examples given.

A twenty-eight year old male, whose wife suddenly left him six months ago, is finishing his first counseling session. In anguish he comments, "I don't think I can do this counseling thing. I've put all this pain out of my mind. I just don't deal with it. Sitting here and talking has brought it all back. I don't think I can handle it." In response, the counselor comments,

Your pain is evident to me. And while you say that you've put the pain out of your mind, you also have told me during our hour together that your work, health, and relationships have suffered in recent months. Part of what we will accomplish in our sessions is a healing process. We will talk about what your wife's leaving has meant to you. In time you will be able to integrate this meaning, understand it, and have it become a part of you. Although it is very painful for you now, over time you will feel less pain as you understand and accept this relationship and your part in it.

The clinician in this illustration has just made use of a "teachable moment" in counseling.

What is a Teachable Moment?

In the *Dictionary of Education*, Good (1975) defines a teachable moment as "that moment when the pupil recognizes a problem and conditions for learning are optimum" (p. 586). A teachable moment, as evident in the above

case illustration, is a unique occasion when the "client-student's" receptiveness and cognitive readiness, the "clinician-teacher's" ability to recognize the moment and successfully impart knowledge, and the optimal learning environment coincide to produce a moment of exceptional learning.

The "teachable moment," is a concept which has been a mainstay in education throughout the past thirty years. The value of the teachable moment has been demonstrated in a number of arenas. These arenas include the following: parents' choice of day care (Honig, 1987), maximizing cognitive growth of handicapped infants (Langley, 1980), and in numerous content areas: reading (McAloon, 1992), non-traditional team sports (Hedlund, 1990), and English as a second language (Roth, 1982). Further teachable moments have been employed in fostering diversity (Ellis & Llewellyn, 1997; McDaniel & Moreland, 1994), responding to bullying (Briggs, 1996), and suicide prevention (Kittleson, 1994). Beyond the classroom, the concept of a teachable moment has found its place in the corporate arena (Bell, 1997; Byham & Pescuric, 1996).

The dynamics which make teachable moments so critical in the classroom and boardroom are equally relevant in counseling sessions. The current article provides guidelines for counselors seeking to respond to the teachable moments found within their counseling sessions.

Teachable Moments and the Counseling Process

During the past two decades, there has been a movement in counseling from the non-directive approaches historically employed to the realization of an ever increasing body of information which provides direction to therapeutic interventions (Fisch, Weakland, & Segal, 1982; Martin, 1994). These more directive approaches provide the opportunity to employ teachable moments. For example, a mid-twenties female who has just miscarried may require assistance understanding that she is experiencing predictable stages of grieving. A mid-life male may need help understanding the role that his 'self-talk' plays in maintaining his depression. Parents of an adolescent diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) need to understand that there is significantly more conflict in their family as compared to a family with a non-ADHD adolescent (Barkley, Fisher, Edelbrock, & Smallish, 1991). However, the therapeutic effect of these interventions may be somewhat determined by the degree to which they are delivered at teachable moments.

Planning and Executing Teachable Moments in Counseling

According to Rinne (1997), "In conventional teaching, teachable moments *happen*. In excellent teaching, teachable moments *happen and are planned*" (p.

131). The same is true in counseling. Novice counselors may experience all the necessary elements for a teachable moment, but may not be able to capitalize on the learning. Or a moment may happen but they cannot recreate it. However, as counselors' knowledge increases about such moments, they will become more adept at planning and executing teachable moments within the counseling process. In the process of planning a teachable moment, a counselor needs to consider three important ingredients: timing, delivery, and mode.

Timing

Bell (1997) has stressed the importance of timing in his definition of a teachable moment. It is "a combination of the learner's readiness to learn, the quickness with which learning can be applied, and the special conditions likely to foster and support learning" (p. 32). Essential to this timing is the accurate determination of when a teachable moment should be executed. Timing encompasses three areas of readiness: the client's emotional, cognitive, and contextual readiness. Counselors must be cognizant of periods of their clients' emotional and cognitive blockage. Many clients appear emotionally stuck and cannot progress. At other times, clients appear on the edge of understanding but are unable to arrive at the conclusion or insight on their own in the absence of a counseling intervention. These occasions are ripe for teachable moments.

However, knowing that a client is in need of a teachable moment does not necessarily insure its effectiveness. To be effective, the teachable moment must be presented when the client is emotionally and cognitively receptive. The client's emotional and cognitive readiness must be assessed in planning for successful teaching moments. Clients are more emotionally receptive to these moments when rapport has been developed between counselor and client, and the client experiences trust and safety in the relationship. Emotional receptivity to new insights in the beginning sessions of counseling may be premature for many clients. For example, a college sophomore, who has been referred because of alcohol infractions, states that he does not have a problem because he only drinks on weekends. During initial sessions, he may not be receptive to the knowledge that alcoholism is defined by the loss of control in his life created from drinking rather than the number of days per week he drinks. Only after trust has been established in the relationship will he be receptive to the delivery of this new insight at an optimal teachable moment.

A client's cognitive readiness is also necessary to fully integrate teachable moments into the counseling dynamic. Lev Vygotsky (1978) highlighted the importance of intervention during specific times in the learning process. Vygotsky identified the "Zone of Proximal Development" as that interval

wherein the student can master a task or gain the intended insight if given appropriate help and support. This is truly a teachable moment. Similar moments occur within the counseling process. For example, a ten-year old male who is of limited intellectual ability and processes information concretely may not fully comprehend that he needs to ignore children on the playground for their teasing to cease. By comparing the children's teasing to a car which must run out of gas before it stops, the counselor provides a concrete metaphor at the boy's cognitive level. This enables him to put their teasing behavior on extinction. The counselor's assistance enables the boy to gain insight and change his behavior.

One final element to effective timing is the availability of contexts in which the client can quickly apply the knowledge of the moment. This quick application allows learning and integration to take place over time as clients practice these behaviors in their daily lives. This shaping process begins initially in the counseling setting and extends to clients' daily living. Within the session, counselors can first test clients' understanding of the moment by having them summarize what it means for them. This may likely evolve into a discussion about the moment in which clients can personalize it for themselves. Behavioral rehearsals and role playing are additional means of integrating meaning. This new knowledge can be further integrated by assigning homework between sessions.

Delivery

Fundamental to the effective use of a teachable moment is the tailoring of the presentation to the unique developmental demands of the client. In addition to developing a trusting and safe environment for the client, the counselor must be able to accurately assess the client's level of cognitive development, including how the client constructs knowledge, processes information, and what effect the client's culture and ethnic background have on this aspect of development. The effective delivery of a teachable moment tailors the language and knowledge imparted to this level of development. This is demonstrated in the before mentioned example of the boy and teasing.

The counselor must also be able to recognize the client's patterns of behavior. In many ways, the counseling relationship serves as a microcosm of the client's real world, and the client will employ many of the same maladaptive behaviors and thoughts in session. For successful delivery of a teachable moment, the counselor needs to be aware of these patterns and be able to illuminate the similarities to the client. The counselor must also consider if the knowledge is culturally consistent with the client's beliefs and values.

Further, the counselor must be able to match the manner or medium of the message to the client's development. For example, in helping a six year-old

cope with her parents' divorce, the teachable moment may better be achieved through reading a book on divorce rather than through abstract conversation.

Mode

Responding to a teachable moment can take many different forms. Three modes of response, including counselor modeling, reframing, and metaphor, will be explored in depth with examples given of each.

Counselor modeling

Counselor modeling is the primary means by which counselors can present teachable moments in their work with clients. This modeling includes the counselor's manner in session, counselor self-disclosure, and specific techniques such as role-reversal. Although the counselor is considered a symbolic model in most therapeutic approaches, illuminating and expanding this dynamic brings it to the realm of teachable moments. This allows counselors to use modeling more effectively.

Counselors can achieve teachable moments through their personal presence and by modeling the specific behaviors or personality characteristics desired for the client to develop. Modeling those desired characteristics in our clients also serves as important, yet frequently unspoken lessons. These qualities may include assertiveness, risk-taking, self-disclosure, and humor. For example, commenting that the counselor's and client's time in session is too valuable to waste is an important lesson in assertiveness to a perennially late client.

Counselor self-disclosure also utilizes modeling as a teachable moment. Self disclosure is "a conscious, intentional technique in which clinicians share information about their lives outside the counseling relationship" (Simone, McCarthy, & Skay, 1998, p.174). Self-disclosure is employed appropriately when used in the client's best interest to facilitate a therapeutic outcome. As a mode of responding to a teachable moment, self-disclosure can build rapport, model coping skills, instill hope, build a sense of universality, and help clients consider a different viewpoint (Matthew, 1988; Simon, 1988). Egan (1998), notes, however, that self-disclosure must be used with discretion. As with other teachable moments, timing and delivery are critical. The amount of information disclosed, the intimacy of this information, and the time spent disclosing must be considered (Cosby, 1973). Counselors must also be flexible with their disclosures and appraise how they are affectively presented (Chelune, 1976).

This author has developed valuable teachable moments through the use of self-disclosure in clinical work. As the parent of an ADHD adolescent, this

author has shared selected anecdotes of disorganization, opposition and creativity in clinical sessions with parents of ADHD adolescents. These disclosures are very comforting to parents with ADHD children, helping them to better understand the disorder and reduce blaming their parenting.

Reframing

Reframing is the second mode of responding to a teachable moment. As a therapeutic technique, reframing helps clients broaden their restricted perspectives. Reframing provides new meanings or frames of reference in a constructive direction (Guterman, 1996). Counselors help clients redefine their problems in broader more constructive directions which encourages behavior change. As a mode of responding to a teachable moment, reframing promotes a perceptual shift within clients, enabling them to control the problem rather than the problem controlling them.

For reframing to be effective, the elements of planning and executing teachable moments should be considered. Counselors need to be mindful of timing and clients' readiness to receive and understand the reframe. Reframing is most effectively employed when it is related to clients' immediate feelings of distress (Clark, 1998). This includes selecting a reframe which clients are likely to accept, based on their values, beliefs, and priorities (Fisch, et al. 1982). The reframe should be suggested by counselors in an inviting tone rather than a dogmatic one. Ideally, this reframing may come from the client himself. For example, a tenth grader complains that his science teacher is "out to get him". When asked about any other possible explanation for his teacher's behavior, the student concedes that the teacher really wants him to pass and is pushing him to succeed. Processing the reframe will allow time for the client to assimilate the new perspective. Finally, homework between sessions can be used to further enhance this new conceptualization. In the above example, the student may be asked, "This week, look for examples of how your teacher is pushing you to succeed".

Another example of the benefits of reframing in response to a teachable moment is seen in the case of an infertile couple who adopted a four year-old with an extensive history of physical abuse and neglect. The boy, who had been diagnosed with behavior and attachment problems, responded to his new parents overtures of love and acceptance with flat detachment and withdrawal. This disconnection continued over time. Finally, in despair, the parents sought counseling to handle rejection and loss of the ideal family they had envisioned. The counselor asked the couple where the child would be if they had not adopted him. They readily agreed in some sort of residential placement. The counselor then asked them to temporarily imagine themselves as the residential caretakers of this child. This reframing of their role

helped them to pull back, allowing them to grieve their losses, accept the reality of his abuse, and not be constantly hurt by his detachment. Teachable moments can also be achieved through the use of metaphors, a technique frequently used with reframing.

Metaphors

Haley (1985) describes metaphor as any communication that can have more than one meaning. In counseling, metaphors motivate clients, allow them to make thought connections, and handle difficult material (Madanes, 1981). As a technique to be used in teachable moments, metaphors provide instruction which allow clients to connect initially inexplicable events with common, everyday experiences (Hendrix, 1992). Concrete and "real life" metaphors are especially helpful with clients who may process information slowly and have difficulty with the abstract. This was demonstrated in the earlier example relating "a car running out of gas to ignoring teasing". Metaphors can serve as a common language which the counselor can draw upon throughout sessions.

Gordon (1978) notes two steps involved in constructing a metaphor: the client exhibits a lack of understanding of a concept or behavior, and the counselor relates a desired outcome and connecting strategy which ties a common experience to this concept or problem. The common experience can be drawn from everyday experiences, fairy tales, television programs, and public figures. As with reframing, it is important that the counselor choose experiences that are consistent with the client's values, beliefs and cultural background. Metaphors do involve reframing; the problem is redefined to a potentially useful experience (Hendrix, 1992). Counselors can check for understanding by asking clients to apply the principle of the metaphor to other similar situations.

Hendrix (1992) uses the metaphor of spring housekeeping with clients who enter counseling and expect to feel better immediately. In the process of housecleaning, many articles are pulled out into the open and initially more dirt and disarray are experienced. So with counseling, it is important for the client to endure the initial difficult tasks to feel more positive later. This metaphor and the case dialogue at the beginning of this article illustrate how different modes of teachable moments can impart the same message.

Romig and Gruenke (1991) employ metaphors to overcome inmate resistance to mental health counseling. They provide illustrations of metaphors as teachable moments which are geared to the prisoners' cognitive levels and cultural experiences. In one example, a former auto mechanic who committed a crime of rage might be compared to a radiator, which either freezes or blows up. In another example, a resistant inmate whose enmeshed family has made

most of his significant life decisions, can accept the analogy of him wearing a dog collar; each family member tugs at a leash attached to his collar with all the leashes tangled.

Finally, metaphors with reframing provide teachable moments in family and couple counseling, allowing family members to view each other differently. When an affair occurs in a marriage, a metaphor often employed is that of a triangle. At each respective vertex is the wife, husband, and lover. Each spouse has allowed sufficient space in the relationship, so that a relationship of two has evolved to a relationship of three. This allows each spouse to take responsibility in the relationship and not view themselves only as victims.

Conclusions and Caveats

The concept of a teachable moment, which has been used successfully to optimize learning in education, can also enhance change in the counseling process. Developing these moments may be a crucial skill for counselors, especially with those clients who have difficulty gaining insight or skills without assistance. This learning can be utilized throughout the counseling process. As in education, counselors must be aware of timing and delivery. When maximizing these moments, counselors must be cognizant of the client's cognitive and emotional readiness, information processing, and cultural and ethnic background. To ensure integration, counselors need to seek contexts in which the client can apply the knowledge of the moment.

Caution, however, must be voiced when using these teachable moments. Teachable moments can be overused, and in the process, the therapeutic benefits of the basic attending skills are lost. The counseling process and the teaching process are very different. The counseling process and its attendant skills must form the foundation for therapeutic change; teaching skills only serve to enhance this change.

A final issue is training counselors in the use of teachable moments. As with teachers, many counselors do not begin to effectively use teachable moments until they have had moderate counseling experience, typically long after formal training. This experience may allow them to more readily recognize client patterns of readiness, use self-disclosure more comfortably, and develop a repertoire of metaphors, reframes, and other techniques. Counselor educators can accelerate the process through educating students about the benefits of teachable moments in counseling. This includes not only instructing them in specific techniques, but also offering information related to the educational psychology of therapeutic change.

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Media Strategies for Counseling Professionals

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The media provides the public with much information about mental health and mental health professionals. Counselors have an obligation to interact with the media to provide useful, accurate information to the public. In this article, strategies are given to aid counselors for interacting with the media.

The media has changed American culture. Newspapers, movies, radio, television and computer technology have allowed the masses quick access to information, particularly information on various mental health issues. Public interest in mental health issues has been great in recent years (Kirschner & Kirschner, 1997). Movies regularly portray mental illnesses (Wahl, 1995). In fact, Jack Nicholson recently received an Academy award for his portrayal of a man with Obsessive Compulsive Disorder in *As Good As It Gets* (Tristar Pictures, 1998). Counseling professionals are also portrayed in movies, sometimes in a positive light such as the caring therapist in *Good Will Hunting* (Miramax Pictures, 1998), and sometimes in a negative light, such as the unethical therapist in *The First Wives Club* (Paramount Pictures, 1996). Furthermore, a multitude of TV talk shows add to the public's perception of both mental health issues and mental health professionals. According to Heaton and Wilson (1995), "Talk TV is a powerful force in the entertainment world, it undoubtedly holds great sway over the general public's perception of the mental health profession" (p. 208). Fifty-four million hours of "Talk TV" are watched each week (Heaton & Wilson, 1995). Many of those hours deal directly with mental health issues and professionals. Even call-in radio shows deal with the thoughts, feelings and mental health of callers (Henricks &

Stiles, 1989). Americans identify the mass media as their major source for knowledge on mental illness (Bram, 1997). Thus, without ever reading a professional journal or book, people are exposed to a great deal of information on mental illness and mental health professionals.

While viewers may give little critical thought to mental health depictions, their reactions and judgements are often based on what is seen or heard on television or radio (Wahl, 1995). Television shapes our thinking and behavior (Brademus & Jankowski, 1992). Ninety-eight percent of American households have a television (Brademus & Jankowski, 1992). The fact that many people are gathering information on mental health and illness from all media sources has made it increasingly important for counselors to become comfortable with the media and learn to use it to the benefit of both the profession and the general public.

The purpose of this article is to help prepare counselors to work with the media. In doing so, the advantages and disadvantages of working with the media will be reviewed. This will then be followed by strategies for interacting with the media.

Advantages

Conyne (1987) suggests that there are two separate advantages of engaging the media: (a) To promote professional counseling and perhaps one's own practice; and (b) to deliver indirect services to clients. The following section will examine each of these advantages.

There is no question that the public can be well served by good psychological information (Rodino, 1997) and that the media can be an indirect way to help others in the areas of primary prevention (Conyne, 1987). Print and non-print media can provide the public with developmental assistance on a variety of topics such as dealing with a relationship, loss of a job, parenting and dealing with grief (Drum & Lawler, 1988). Given the public's fascination with the media, professionals should invest more time communicating with the public as well as working with media professionals to begin advocating for accurate information (McCall, 1990). In fact, media psychology offers counselors "new and exciting opportunities to examine their skills, training and insights" (Kirschner & Kirschner, 1997, p.173). Furthermore, media psychology can show the public how the world impacts on individuals and families and how people impact the world around them (Kirschner & Kirschner, 1997).

Another benefit of interacting with the media is that individuals who would otherwise not receive help can benefit from indirect services (McCall, 1985; McCall, 1990). Furthermore, Morrill, Oetting and Hurst (1974) advo-

cated using the media for remediation, prevention and development especially with "hard to reach" individuals and groups. Thus, where language might pose a barrier, non-English language channels can help counselors to maintain more access (Schillings & McAlister, 1990). Additionally, "Low-income and ethnic-racial minority families watch and listen to more television and radio" than dominant culture and high-income families, and, therefore, may be easier to reach through the media (Schilling & McAlister, 1990, p. 417).

Increasing access to psychological information in the media may also give consumers the opportunity to think about and consequently, change some of their own behaviors. For example, parents may see a different way to handle a child's tantrum in the grocery store or couples may learn new ways to talk to each other. In other words, interacting with the media makes accurate information and different perspectives more accessible to the public.

Since people don't always talk about their problems, they may feel isolated and fearful. Presenting psychological information in the media can help assure people that they are not alone, and that there are alternatives to how they are currently handling a situation (McCall, 1990). Looking at new options often provides the individual with renewed hope. This increased awareness of one's problem and additional alternatives for solving it can help audiences reach more reasoned decisions.

Schillings and McAlister (1990) have discussed the benefits of media psychology repetition. They contend that as consumers repeatedly learn about various mental health issues and hear discussions on how to live more psychologically healthy lives, their behaviors may begin to change accordingly.

Like every other discipline, the public sometimes projects a stereotypic and negative image of counselors. As a result, an additional advantage of counselor media involvement lies in the potential to dispel negative stereotypes. McCall (1990) has underscored the benefit of working with the media to present mental health and illness issues in an ethical manner thus helping to enhance the image of counselors.

Because the media offers a public forum, it allows counseling professionals an opportunity to advocate for new laws that make mental health services affordable and accessible to the general public (Sleek, 1997). The American Counseling Association Code of Ethics states that it is the "primary responsibility of the mental health professional to respect the dignity and promote the welfare of all clients" (American Counseling Association, 1995, p. 2). Clearly this section of the code reinforces the counselor's responsibility to advocate for the welfare of all consumers. Consequently, the media provides a natural forum to increase awareness and to advocate for public policy.

Finally, working with the media affords the counselor the opportunity to increase referrals (McCall, 1990). Nine out of 10 people are reached by television, 7 out of 10 people are reached by radio and newspaper, and 3 out of 10 by magazines making the media one of the easiest and fastest ways of communicating with a multitude of people (Brademus & Janowski, 1992). Increasingly, the Internet is becoming a significant force for disseminating information and communication. According to the Richmond Times Dispatch (Jan. 19, 1998), "40 million Americans are on the Internet" (p.1). As the mental health field gets more competitive and diversified, counselors may want to utilize the media to reach a wider referral base.

Disadvantages

Although there are many positive reasons for counselors to interact with the media, there are disadvantages as well. One of the biggest disadvantages of working with the media is time constraint. Regardless of media format (newspaper, radio, Internet or television), one of the glaring problems is that the time given the counselor is usually too brief (McCall, 1990). Furthermore, the counseling professional often has no control over how much of their message is used (McCall, Gregory & Murray, 1984). Even though the counselor presents material ethically, the tape or article may be edited in a way that inaccurately represents what the professional meant to communicate (Heaton & Wilson, 1995). In reality, it is difficult to deal with complex issues, especially in television, because of the time constraints (Levy, 1992).

The idea of "fast-food therapy" can lead to drastic misperceptions about what therapy is and how the therapy process occurs (Keith-Speigel & Karker, 1985). Counselors need to be certain that they do not give the impression that mental health problems can be resolved in a few minutes (McCall, 1990). Section A.3. a. of the American Counseling Association Code of Ethics (1995) states that counselors must "inform clients of the counseling process, goals techniques, procedures, limitations, potential risks and benefits of services" (p.2). Clearly, allowing consumers to believe that their problem can be resolved in a matter of minutes challenges this section of the code.

Since the media provides entertainment for financial gain, one of the hardest tasks of the counseling professional is to walk the line between being entertaining enough to attract an audience while remaining professional (Broder, 1989). Since the welfare of the client is the primary responsibility of the counselor (ACA, 1995), it is imperative that the counselor remain focused on client welfare. This may be difficult because professionals are often seduced by the media. It is, often times, easy for the counselor to get caught up in the media's glamour and excitement (Heaton & Wilson, 1995). Unfortunately, the glamour and excitement can feed the counselor's narcissism

(McGrath, 1997). The focus then moves from the client's needs to the ego needs of the counselor. By consulting with colleagues, the counseling professional may increase the likelihood that the focus remains centered on client welfare rather than the ego needs of the counselor.

For all of its limitations, there is still "no better way to influence both the general public and policy making than through the mass media" (Becker-Lausen & Rickel, 1997, p.118). Therefore, counselors need to learn to work with the media to meet the needs of the public. Collaborating with the media can lead to broader, better publicized interventions more likely to change behavior (Jason & Salina, 1993). The American Psychological Association Commission on Violence and Youth (1993) states "television and other media can contribute to the solutions rather than to the problems of youth violence" (p.77).

Utilizing Computer Media

The newest form of media intervention is the Internet. For the past thirty years, computers have been used in the delivery of counseling services (Sampson, Kolodinsky & Greeno, 1997). Professional counselors have routinely used computers to assist in career and college choice, job placement, test administration and scoring. With the widespread use of the Internet, counselors are finding new and exciting ways to utilize computer technology and refine their media skills. The Internet "offers access to information and group formation never previously encountered" (Lebow, 1998, p.203). This has fostered concern among counseling professionals for developing ethical guidelines for dealing with Internet services (Bloom, 1998).

One use for the Internet is to provide counselors with new information. The Internet "increases access to empirical and practice knowledge and also facilitates information exchange" among professionals (Giffords, 1998, p.243). The American Counseling Association (www.aca.org), American Psychological Association (www.apa.org) and the American Association for Marriage and Family Therapy (www.aamft.org) all offer web sites with current information for therapists. Additionally, counselors can go online to take continuing education courses (Grohol, 1998). These same sites can also be used to provide excellent information for clients. Giffords (1998) reinforces this notion by stating that "access to information is a valuable tool to assist clients" (p.249). List servers and information resources collections can also be useful for counselors in gathering information (Walz, 1996).

In addition to providing information, Internet web sites have also been used to provide therapy. Sampson, Kolodinsky and Greeno (1997) report that there are approximately 3,764 home pages using the word counseling. Fur-

thermore, the web site Concerned Counseling claims to have 150 paid counselors working with clients online and by telephone (Holmes, 1997). Even though there are some concerns about working with clients online, the Internet can offer help to those who do not seek help because of cost, stigma or isolation (Lebow, 1998). It can also be a way to reach clients in remote locations or physically disabled clients who would not have to leave home to get help (Sampson, Kolodinsky & Greeno, 1997).

There are, however, some ethical concerns about offering therapy on the Internet (Giffords, 1998). For example, some who present as counselors may not be what they seem. They may not be credentialed and are more likely to provide information that is inaccurate or unreliable. Furthermore, even credentialed and experienced counselors may not be aware of the local geography, events and customs of clients from remote locations and, consequently, provide inaccurate or inappropriate service (Sampson, Kolodinsky & Greeno, 1997). Since much of the population does not have access to a computer, counselors may not be able to reach less affluent members of society. In addition, information collected over the Internet may be incomplete. As a result, client decisions could be based on invalid data (Sampson, Kolodinsky & Greeno, 1997).

Most counselors would agree that the cornerstone of counseling is the therapeutic relationship. The counseling relationship is based on verbal and non-verbal reactions to client concerns. Therefore, counselors may have trouble developing a therapeutic relationships with clients over the Internet. Since responses on the Internet exclude nonverbals, it makes it more difficult to develop a relationship and communication can easily be misinterpreted (Lebow, 1998).

For the most part, the existing Codes of Ethics and Standards of Practice of the American Counseling Association and the National Board of Certified Counselors have been developed for face-to-face counseling. Thus, they do not coincide with the impersonal interactions of the Internet. Consequently, the National Board of Certified Counselors (NBCC) wrote and implemented the NBCC Webcounseling Standards (Gilbert & Lawson, 1998). A summarized listing of these standards are:

1. Mental health professionals must develop practice and clinical guidelines for Internet mental health practice.
2. The therapeutic relationship must be maintained and confidentiality is essential.
3. All client encounters must be documented including treatment plans, recommendations and encounters with other providers.

4. Clients must be informed about process, risks, benefits, rights, responsibilities and consent. The safety of the client and practitioner must be ensured.
5. Systematic research must be developed.
6. Practitioners must be aware of geographically remote, location-specific events and cultures and supply appropriate referral sources as needed.

Despite limitations, Internet interactions seem here to stay. Therefore, counselors need to heed the new standards in order to develop Internet utilization strategies that are beneficial to the clients they serve.

Preparing for Your Media Presentation

Knowledge, preparation and training could make interactions with the media more "user-friendly." In fact, McCall (1983) states that "if you are cooperative, prepared, and knowledgeable about the media's values, needs and procedures, you lessen the risk" (p.322) of being misquoted, providing inaccurate information or mishandling audience concerns. One of the first steps in the preparation process is for counseling professionals to develop a cooperative relationship with media professionals. Since counselors are trained in communication skills, they can capitalize on those skills in preliminary discussions with media professionals. It is important for counselors to know what to expect from the media format, to stay within an area of competence, and to be fully prepared for any interaction with media professionals.

In the initial stages of preparing for a media presentation, it is important for counselors to develop a collaborative, consultive relationship with the media professional (Wahl, 1995). Both sets of professionals have apprehension about working with one another. Media professionals may be concerned that counselors will use psychological jargon and will be unable to convey information in a clear and concise way. On the other hand, counseling professionals may be concerned, for example, that media professionals will edit inaccurately causing misinterpretation of their communication. Therefore, it is imperative that well-meaning counseling professionals seek out well-meaning media professionals (Becker-Laussen & Riskel, 1997). According to Wahl (1995) "Efforts to reduce the barriers and establish trust, understanding and cooperation between the two fields as one step toward improving media images of mental illness are needed" (p.158).

After the initial trust building stage with media professionals and before saying yes or no to a particular media presentation, Heaton, Pillay and Brooker (1997) recommend that counselors consider several suggestions.

First, the counselor should know the tenor of the show including the main theme, the program length, length of the particular segment and the role the counselor will play in the segment. Furthermore, the counselor may want to see a sample of a particular work of the show, viewing a clip or transcript. Heaton and Wilson (1995) also suggest that counselors may want to talk to other professionals who have spoken with particular media professionals to get a more accurate picture of what working with them would be like. If there will be other contributors on a segment or to an article; the counselor should make an effort to research the professional reputation of the contributors, as well as to clarify their own role in the project/presentation.

Before appearing on a television or radio show or writing an article, counselors should ask themselves the following questions. Who will be the audience/readers? Will the audience/readers have the opportunity to ask questions/respond? Will the program or article be edited? Will the counselor be able to see the editing before broadcast/print (McCall, Gregory, & Murray, 1989; McCall, 1987)? Finally, before the show or article the counselor should set some ground rules for the presentation taking into account the information gathered from the questions above (Gregory & Murray, 1984). For example, the counselor may want to meet the host of the show and/or establish some questions that would be good stimulants for discussion. Once the counselor is satisfied that he/she understands the host, the format and the editing procedure, the counselor can decide on how to present their material.

After gathering this preliminary information, the counselor must decide if he or she is the appropriate source of information. Counselors should ask themselves if they feel comfortable with the role they are being asked to play and to think about what kind of guest they want to be: Controversial? Confrontive? , etc. (McCall, 1987). It is wise for counselors need to remember that they are not experts on everything and they may need to involve other professionals as indicated (Tanenbaum, 1997). If a counselor is appearing on television, it is important to make sure that post-show counseling services are available for guests and that guests are not too numerous to manage. To make sure that guests are appropriate for a particular television segment, some counselors require a preshow assessment or screening of guests (Heaton & Wilson, 1995).

Once the decision to make a media presentation has been made, some general guidelines are offered. Before any media presentation, counselors need to indicate that they are providing education and not therapy (Stiles & Hendricks, 1989). McCall (1985) suggests that counseling professionals also avoid advice giving, diagnosing problems and prescribing specific action. Keeping in mind the educational aspects of the presentation, the material presented should be based on appropriate psychological literature and con-

sistent with the counselor's ethical codes (Heaton & Wilson, 1995). In presenting information, remarks should be confined to the area of training and expertise of the counselor (Cialdini, 1996; Keith-Spiegel, 1985). While all problems should be discussed in general terms (McCall, 1990), it is important to remember to differentiate between personal and professional opinion and not speak for the discipline as a whole (Broder, 1989). As in all educational and therapeutic endeavors, counselors should use good judgement (Martin, 1996) and be sensitive to the needs of minority and special interest groups (McCall, 1990). As mentioned previously, the welfare of the consumer is always the primary concern (ACA, 1995).

In preparing the content of a media presentation counselors may want to identify some specific tasks. Initially, the counselor should decide what information is important to present, taking into account what the main points are and rehearse without memorizing (McCall, Gregory & Murray, 1984). It is also important for the counselor to clarify, with the media professional, their specific degree, training and experience in order to provide an accurate introduction of the counselor's level of expertise (Heaton & Wilson, 1995; McCall, 1990).

While actually doing the media presentation, the counselor should possess self-awareness of both verbal and non-verbal behavior. As in any counseling interaction, it is important to speak clearly and to be heard. It is also important for the counselor to be aware of intonation and inflection (Tanenbaum, 1997). In order to gain the attention of the audience, it is helpful to display an attitude of cooperation and respect, avoiding jargon, while maintaining good eye contact and posture (McCall, 1987; Stephenson, 1997). Counselor training should help in identifying and avoiding mannerisms that may be annoying (Tanenbaum, 1997). McCall et al (1984) even suggest that if the counselor is presenting in a visual medium to dress conservatively so that they will appear more professional on camera.

Various experts have posited recommendations and cautions for counselors considering interactions with the media. Stephenson (1997) suggests that counselors know exactly what to say and always tell the truth. To maintain their credibility it is important for counselors to be confident in their expertise and strengthen their expert opinion by citing research/facts/statistics. Some counselors assume that because they are being interviewed, all they have to do is answer questions. In order to insure that the interview move in a direction that the counselor is comfortable with, the counselor must also take control of the interview. Part of taking control is owning what one says and always assuming that what is said is "on the record".

Working with the media can tend to distract the counselor and be frustrating because it is a medium that counselors do not have much experience with.

Therefore, counselors should concentrate completely on the process as it is taking place. If the host asks questions for which there is no scientific data, the counselor can deflect the question. There is no reason that the counselor should believe that they have to answer every question (Becker-Laussen & Rickel, 1997). Counselors should never bluff, if the counselor does not know an answer, the counselor should say so (McCall, Gregory & Murray, 1984). Counselors should, however, be sure of their facts (Stillman, 1997) and emphasize positive actions to be taken (Stephenson, 1997). Some media professionals may want to exploit the misery of their guests. However, counselors should not be part of that exploitation and they need to do all that is possible to prevent it. At the same time, counselors should not use the opportunity to provide therapy, remembering that the counselor's presentation should provide education and not therapy (McCall, 1990). Counselors should never use their own clients as guests (McCall, 1990; Heaton & Pillay, 1997) or make self-referrals (Stephenson, 1997).

Some television hosts will ask the counselor to evaluate someone on the air or to comment on some aspect of the guest's behavior. Counselors should not evaluate someone that they have not met or comment on an area in which they have insufficient knowledge. If asked to do such an evaluation, the counselor should refuse comment and refer the guest to someone better suited to give feedback (Keith-Spiegel & Karker, 1985). If it is a call-in show, the counselor should insure that there is a procedure so that all calls can be carefully and professionally screened. Counselors are advised not to give specific advice, however, in some instances it may be warranted. For example, if a guest or caller is suicidal/ homicidal, then the counselor may want to give specific, concrete advice (McCall, 1985). Finally, after each televised episode, the counselor should make sure that there is follow-up and monitoring of all guests (McCall, 1990).

Developing Print Media

In addition to dealing with the visual medium, counselors also need to learn to develop effective print media. The following suggestions may be helpful in developing print media. Some counselors advertise their counseling and consultation services with posters and brochures. Posters and brochures advertising counseling and consultation services should be attractive, avoid overcrowding with words or graphics. To reach their audience, counselors should place posters and brochures in high traffic areas that their intended audience may frequent. Some counselors choose the newsletter as a way to reach their intended audience. Newsletters can be particularly effective if they are used to reach groups with a global theme (Drum & Lawler, 1987). For example, counselors who work with Employee Assistance Programs (EAP) may choose to do a monthly newsletter with article and upcom-

ing events of particular interest to EAPs and those they serve. Fortunately, posters, brochures and newsletters can be developed much more efficiently with new technology and resources. Computers, for example, can be helpful in producing high quality graphics (Conyne, 1987). Laser printers produce text that is attractive and professional. In addition, office supply stores now offer an assortment of brochure, letterhead, business card and poster paper that is attractive, professional and inexpensive. If the counselor chooses not to develop their own print media, they can turn to local, metropolitan, campus and county newspapers and periodicals. Most local, metropolitan, campus and county newspapers will accept standard news releases and they may even do a feature story that is timely or particularly relevant at any given point. If the counselor's efforts at producing unpaid advertisement and information for newspapers goes unrewarded, all newspapers will accept paid ads (Drum & Lawler, 1987).

Counselor Training

Since most graduate schools do not train counselors to work in the media, practitioners must take it upon themselves to learn the necessary skills (Kirschner & Kirschner, 1997). Additionally, the helping profession itself has not prepared adequate up-to-date guidelines for when and how to present in the media (Heaton & Wilson, 1995). This is of particular concern because the media is the most powerful vehicle for getting the mental health professionals' message to the public (Cialdini, 1997). Both the media and society will benefit from closer cooperation. It is, therefore, imperative that counselors get the training and expertise to work in this medium (McCall, 1990). Heaton and Wilson (1995) suggest the following ways in which professional organizations can facilitate the needs of their membership in learning media presentation skills:

1. Use the media positively to inform the public and fight inaccurate information about mental illness and mental health professionals
2. Use more aggressive marketing strategies to distribute existing information to the public
3. As needed, review and modify existing ethical codes to ensure that media interactions are adequately addressed
4. Dedicate divisions of professional organizations to handle media issues
5. Identify mental health professionals who are media experts
6. Offer professional training on a state and national level to interested mental health professionals

7. Encourage the inclusion of media training in graduate counseling courses
8. Encourage scholarly research and discussion regarding the impact of media on guests, viewers and professionals

Although there are drawbacks to working with the media, it is clearly advantageous for counselors to develop ethical and effective strategies for dealing with media interactions. This responsibility lies with the individual and with the profession. Counseling and media professionals must develop collaborative and positive relationships to benefit each discipline and society.

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The Diagnostic Dilemma: Implications And Concerns For Use Of The DSM-IV In A College Or University Counseling Center

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Prospective information regarding the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (American Psychiatric Association, 1994) is presented. Historical background, clinical and cultural implications, and concerns for college and university counselors are discussed.

DSM-IV in a College or University Counseling Center

Historically, the philosophical orientation of college and university counseling centers has taken the view that emotional development is influenced by a variety of factors: emotional, vocational, academic and personal (Williamson, 1939). The diagnostic role of mental health meanwhile, was typically delegated to attending psychiatrists, or off-campus mental health centers (Aubrey, 1977). Counseling in college and university centers was typically conducted from a developmental framework and did not generally involve the use of diagnostic labels (Williamson, 1939).

During the 1930's and 1940's questions were emerging about the role of counseling in higher education. At that time, college counselors represented the various student personnel programs, as well as the field of psychology, education and social work. Some faculty even argued that faculty should receive general counseling training to carry out the developmental needs of students, while professional counselors would be used by students with more severe psychological problems (Lloyd-Jones and Smith, 1938).

At the brink of the second millennium, college counseling's traditional developmental role is under intense scrutiny, as an increasing number of

college and university counseling centers now utilize some type of diagnostic approach (Gallagher, 1998). College and university counselors, many of whom were trained from a "healthy" developmental framework, may struggle with a taxonomy that appears to create medical pathologies for what many counselors may view as typical adjustment issues (Ivey & Ivey, 1998). In light of their position, college counselors are likely to continue to be involved in this continuing controversy as they provide the front-line mental health service to scores of college students. Perhaps, as a parallel process, the use of the *Diagnostic and Statistical Manual of Mental Disorders*, (1994), has seen a dramatic increase in counselor education training (Hinkle, 1994) and in college counseling center use (Gallagher, 1998). Though there are still many questions regarding the usefulness or even the ethics of such a system, many would agree that the DSM system is a necessary tool when counseling students with psychiatric disorders (Bihm & Leonard, 1992). The purpose of this article is as follows: (a) to review the history of the DSM; (b) to review the advantages and disadvantages of the DSM; (c) to discuss the implications for college and university counselors.

The Advantages of the DSM System

The advantages of implementing the DSM system include the use of a common mental health language, an increase in the use of behavioral operations, the advancement or prescriptive therapies, facilitation of the overall understanding of psychopathology and an increased awareness of cultural influences (Smart & Smart, 1997; Hinkle, 1990). The range and scope of counseling in university counseling centers is changing as reflected by the increased number of university counseling centers utilizing the DSM system (Gallagher, 1998). Graduates of counseling programs are securing positions and providing counseling services in areas of mental health, including university counseling centers that previously were limited to psychologists (Ivey & Ivey, 1998). With the Adults With Disabilities Act (Adults With Disabilities Act) of 1973 providing protection for people with mental illnesses and disorders, some research indicates that colleges are seeing more students with major mental illnesses, and possibly making psychodiagnosis more of a necessity in many college and university counseling centers (Schwartz, 1998). The DSM system also undergoes periodic revisions, which may assist in keeping DSM current with research and while many counselors certainly question the validity of DSM terms, DSM terminology makes it easier to bill third-party providers (e.g., HMO's) (Ivey & Ivey, 1998).

The Disadvantages of the DSM

The disadvantages of using the DSM would include the promotion of a

technicians "cookbook" approach to mental disorders; a false impression that the general understanding of mental disorders is more advanced than is actually the case; and an excessive focus on the signs and symptoms of mental disorders to the exclusion of a more in-depth understanding of the client's concern (William, Spitzer, & Skodol, 1985, 1986). The DSM system of classifying mental and emotional disorders into a medical taxonomy is not without controversy (Miller, 1996). One possible contributing factor might come from the American Psychiatric Association (1994) which has acknowledged that inter-rater reliability of DSM diagnoses is very low. Although literature concerning use of the DSM in counselor education training programs is not common, Seligman (1986) reported that assigning a diagnosis to a client is uncomfortable for many mental health counselors.

An additional disadvantage, is that according to Hammond and Wilson (1996), the DSM system, with its lack of objective standards, contains a high degree of error, and is potentially biased in the view it presents of women and ethnic minorities (Hammond & Wilson, 1996). Seem and Hernandez (1997) have been very critical of the DSM-IV for what they view as the Manual's insufficient attention to feminist and cross-cultural issues. Additionally, Miller (1976) commented, "Once a group is defined as inferior, the superiors tend to label it as defective or sub-standard in various ways" (p. 6). Given the large number of educational and training programs related to campus diversity, utilization of the DSM system may appear a contradictory practice in an era of heightened campus sensitivity, given that it may unfairly pathologize groups such as women and minorities. The existence of these unresolved and controversial issues appear to have significant implications for college and university counselors.

Implications for College and University Counselors

Perhaps the most significant issues that college and university students deal with are developmental or adjustment concerns (Pascarella & Terenzini, 1991). Adjustment issues may be understood as one of a variety of concerns, such as separation from family of origin, choosing an academic major, living in university housing, and defining support or friendship group (Pascarella & Terenzini, 1991). Adjustment concerns are typically the focus of non-clinical or developmental counseling with "healthy" populations as opposed to psychotherapy dealing with psychopathology. A major question for university counselors is, "Does this issue present a developmental concern, or does it involve some type of mental disorder or illness?" Because university counseling centers often refer students to medical and psychiatric professionals, there is frequently external pressure from medical professionals to use diagnostic labels (Ivey and Ivey, 1997). The larger concern for university

counselors using the DSM, lies in the inherent pathologizing of transitional issues (separation from family, changes in previous relationships, stress from novel situations, etc.) which may not fit with the university counseling model of serving the developmental needs of students.

A second issue is, "Does such a system (i.e., DSM-IV) promote the stigmatization of those who seek counseling by over reliance on psychiatric labels that are often erroneous?" Some professionals within the counseling profession have long maintained that the distinction between typical adjustment concerns, as opposed to psychosis, is often difficult to make (Ivey, Ivey, & Simek-Morgan, 1997; Levers and Maki, 1994). For example, does an individual presenting with a depression issue, precipitated by the ending of a relationship or the sudden withdrawal of familial support, really need to be diagnosed with Dysthymia, Adjustment Disorder, or another related Axis I mental disorder? Is a non-bizarre delusion experienced by a late adolescent really better accounted for through the employment of medical model and diagnostic terms, as opposed to an educationally based and informal counseling assessment? These are questions that counselors trained in a developmental model must confront in a realistic manner, as they work to balance the demands of a medical-model system (e.g., DSM-IV) while maintaining sensitivity to developmental concerns.

Then again, what do the diagnostic terms so popularized by the DSM system actually mean? According to some noteworthy scholars, the motivation for reliance on clinical terms and categories serves primarily as a comfort to the clinician (i.e., an attempt to create order from chaos) and a requirement for insurance billing purposes (Murphy & Davidshofer, 1988), rather than a vehicle to facilitate the therapeutic process (Seligman, 1997). It must be emphasized, however, that many professionals counselors, in systems as diverse as public medical-model clinics, K-12 school systems and university counseling centers, embrace the DSM-IV as a legitimate and necessary function of the counseling process (Hohenshil, 1996).

History And Development of The DSM

In 1917, the American Psychiatric Association developed its original classification system, which included a listing of some 60 disorders (Pincus, Francis, Davis, First, & Widiger, 1992). By the early 1950's, the DSM had increased significantly to 106 diagnoses, and each subsequent revised edition has increased by similar volume (Pincus et al., 1992). The current system, DSM-IV, includes several hundred diagnoses, including an Appendix on Culture-Bound Syndromes. This growth and expanding number of diagnoses suggests an effort to be more inclusive than exclusive (Hinkle, 1994).

The history of mental classification has long been a source of controversy. In the early 1980's, Kendall (1984) stated that a major difficulty with the further development of the diagnostic classification would be in adequately defining what constitutes a mental disorder. More recently, Wakefield (1992) has argued that the DSM concept of "mental disorder" might better serve clients and clinicians if it were referred to as a concept of a "harmful dysfunction." He based this concept on numerous citations that have suggested that the Diagnostic and Statistical system of classification is used to control and stigmatize behavior that is actually more socially undesirable than disordered (e.g., Wakefield, 1992; Eysenck, Wakefield, & Friedman, 1983; Horowitz, 1982). Furthermore, Wakefield (1992) has indicated that "our culture clearly disvalues such conditions as premenstrual syndrome, hyperactivity, and alcoholism, and yet there are ongoing disputes about whether each of these is a disorder" (pp. 376-377). Davis notes that "bad writing (315.2), coffer nerves (305.90) and jet lag (307.45) are examples of how the field has pathologized even the most normal of behaviors" (1997). While some behavioral disorders are medical in nature, it is not clear whether the concept of "disease" is appropriate for describing a number of problems of daily life (Murphy & Davidshofer, 1988). For example, some clinicians regard the diagnosis Premenstrual Dysphoric Disorder as an attempt to label many women as suffering from a psychiatric disorder, while others may view this as the most helpful term for women whose premenstrual symptoms are extreme (Wakefield, 1992). Perhaps more disturbing, Davis (1997) has commented that nowhere does DSM-IV touch on the nature of normal behaviors. Wakefield (1992) also refers to the belief that disorders and mental illnesses are "whatever mental health professionals treat." Furthermore, many other university and college counseling center directors may insist that a diagnosis be attached to each client, regardless of presenting issues (Schwartz, 1998). Such comments remind us that diagnostic systems may need more balance and attention to a reality base.

Another criticism of the DSM is the contention that with each revision, it has added substantially to the number of existing disorders (Pincus, Francis, Davis, First, & Widigen, 1992). Pincus et al. (1992) observed that it is generally easier to add new categories than to eliminate old ones, as convincing data must be supplied in order to remove a category. Thus, "old categories" typically remain, while new ones are added on. Sometimes categories change names. Multiple Personality Disorders (MPD's) became Dissociative Disorders (DD's) in the DSM-IV revision. While this particular change was a welcome relief for many (reflecting an admission that dissociation is common, i.e., PTSD, not something rare, nor dramatic despite Hollywood's depictions), it is the exception rather than the general rule.

Additional DSM diagnoses are likely to be associated with the identification of "sub-clinical" categories. Including these categories could manufacture increasing numbers of students receiving a mental disorder diagnosis. Moreover, the increasing numbers of diagnoses conceivably leads to the trivialization of the construct of mental disorders and their misuse by professionals and non-professionals alike (Pincus et al., 1992, p.113). While the argument can be made that inclusion of sub-clinical categories could enhance diagnostic precision and accuracy, the proliferation of additional codes and third party interest (i.e., HMO's) appears to drive the mechanics of the diagnostic system more than any focused clinical research (Zimmerman, 1988). It may come as no surprise then, that college and university counseling staff trained in Rogarian or similar human potential philosophies may be reluctant to embrace DSM both for philosophical reasons as well as its lack of clinical base and dubious history.

Diagnostic Implications And Concerns For College And University Counselors

Although the DSM classification system can be initially difficult for those with limited clinical experience or personal familiarity with mental disorders (Skodol, 1987), it is relatively easy for experienced college and university counselors to accommodate it into their system (Malt, 1986). One potential issue for use of the DSM-IV system includes the risk of misuse among the general college community. Another incongruity of this diagnostic system is its incongruity with counseling centers operating on "Wellness" models which advocate that clients be evaluated from cultural, systems and individual framework, and not from a medical taxonomy as with the DSM approach. In our developmental history, most people endure a variety of environmental stressors that challenge our ability to adapt and cope. This is certainly evident among the college population, where students make sudden changes in geography, peer group, academic focus and lifestyle. Such challenges, coupled with an abusive family of origin generates coping behaviors and defense mechanisms which may be quite "healthy" when viewed from the students' perspective. Thus, generating a medical model diagnosis based on defense mechanisms (projection, sublimation, identification, etc.) may be the mental health equivalent of the blind men and the elephant: each has hold of a different part of the animal, but there is no comprehensive understanding of the whole. In the next section of this article, further limitations of the DSM and its appropriateness for college and university counseling centers will be explored.

Limitations Of The DSM

A major shortcoming of the diagnostic system is the lack of standardization in determining or formulating a diagnosis. Ironically, this lack of standardization is exactly what DSM was created and designed to address. Koerner, Kohlenberg & Parker (1996) expressed that the critical test of any diagnostic classification is whether or not it enables more effective clinical intervention. These authors, taking a behavioral perspective, expressed the position that diagnostic classification systems should link "problems, outcomes, and the proposed process of change" (Koerner, et al., 1996, p.). In that view, DSM-IV becomes a potential barrier to client growth due to the absence of linkages useful to the therapeutic process. In addition to these expressed concerns, there also exists no singular format for determining a specific diagnosis (American Psychiatric Association, 1993). Research has indicated that inter-rater reliability between different clinicians using the DSM-IV is very low (Miller, 1996). One of the efforts at standardization among the psychiatric community was the development of the Mini-Scid, a computer program that cross-references Axis I disorders and suggests a diagnosis. The advantage of such a system is that rater bias is removed from the process, theoretically providing for a scientifically objective means of diagnosing mental disorders. The reality of using the Mini-Scid, however, is a program that suggests a high number of false positives on Axis I (Clinical Disorders) of the DSM. Because of the similarity between many different diagnostic labels (e.g., Bi-Polar, Major Depression, Dysthymia, etc.), the Mini-Scid may suggest numerous possible diagnoses (American Psychiatric Association, 1994). In one clinical setting, this author's experience was that 100 per cent of the clients screened with the instrument received at least one Axis I diagnosis. The counseling professional may therefore come to question both the reliability and validity of an instrument that generates such far ranging conclusions.

Multicultural Issues

There have been advances by the mental health practitioners in recognizing the importance of cultural context (e.g., Smart & Smart, 1997). DSM-IV now contains a glossary of key syndromes in a cultural context, and cultural considerations are encouraged in formulating diagnoses. Smart and Smart (1997) maintain however, that while some 20 percent of listed disorders now contain a cultural context, most such descriptions are brief and incomplete. For example, the American Psychiatric Association's DSM-IV includes the following consideration for clinical depression:

Culture can influence the experience and communication of symptoms of depression. In some cultures, depressions may be considered largely in somatic terms rather than sadness or guilt. Complaints of "nerves" and

headaches (Latino culture), weaknesses, tiredness or imbalance (some Asian cultures), of problems of the "heart (Middle Eastern countries), or of being "heartbroken" (among Hopi) may express the depressive experience. (APA, 1994, p. 328)

Nevertheless, depression is still viewed primarily in terms of dominant, Euroamerican society (Ivey and Ivey, 1998). For example, a Latino woman suffering from "nerves" or depression may simply be struggling with the cultural stress of being a woman in Latino culture, or with the issues related to poverty, rather than struggling with the onset of clinical depression (Riveria, 1991). DSM-IV also includes information about depression associated with the onset of menses, but offers insufficient information regarding how ongoing discrimination from a patriarchal society may lead to depression (Ivey and Ivey, 1998).

Furthermore, spiritual and religious issues (under Cultural Bound Syndromes) have been added to the "V-codes". These contextual codes are echoed in the APA's comment on their work: "It is hoped that these new features will increase sensitivity in how mental disorders may be expressed in different cultures and will reduce the possible effect of unintended bias stemming from the clinician's own cultural background" (APA, 1994, p. xxv). There are two major drawbacks with the "V-codes" section: One is that they are not reimbursable through insurance providers. The other is that they are located in the back of the DSM-IV text. This placement may lend them to obscurity and non-use. Both of these limitations may serve to marginalize whatever good intentions the DSM revisionists had in mind.

Conclusion

Since becoming available for use by mental health professionals in 1994, the DSM-IV has become one of the most influential clinical resources in the field. While there is much resistance to using the DSM system, many professionals maintain that it helps them to communicate more effectively with one another (Seligman, 1986). Additionally, it also provides a standardized model for making clinical judgments. (Hinkle, 1994).

Nevertheless, college and university counselors must not overlook the influence of the DSM-IV as a powerful sociocultural tool. University counselors utilizing DSM-IV criteria wield sizable power and influence that may be potentially harmful to certain groups of people (i.e., women, minorities and spiritual/religious people). In addition, the diagnostic reliability of some diagnoses is affected by political and social realities. For example, imagine the backlash from the powerful cigarette and coffee manufactures and lobbyists if nicotine and caffeine abusers were to become popular mental disorder

diagnoses (Hinkle, 1994). Likewise, powerful third-party carriers (i.e., HMO's) bring many non-therapeutic values and interests into the diagnostic process (Zubin, 1984). Clients of lower socioeconomic status may manifest mental disorders differently than middle-class and upper-middle class clients (Pakov, Lewis, & Lyons, 1989). Naturally, it is important to distinguish and understand cultural belief systems from delusions and to understand the special difficulties of clients from diverse populations (Adebimpe & Cohen, 1989). At least one clinical study has reported that African-Americans are far more likely to be diagnosed with schizophrenia than are people of other ethnic origins (Pavkov, Lewis, & Lyons, 1989). In addition, despite efforts at cultural sensitivity, the DSM system remains culturally biased (Ivey & Ivey, 1998; Sue, Arredondo, & McDavis, 1992). For example, many regions within the United States, and many cultures outside, would consider experiences such as conversations with God, out-of-body experiences, and speaking in tongues, as well within the range of "normal" acceptable experiences, while the DSM system, according to Zuckerman (1995) would consider these phenomena as evidence of psychopathology. While some would argue that the DSM-IV's creation of the Appendix of Cultural Bound Syndromes would balance this type of bias, it is again worth noting that the Appendix is located in the very back of the Manual and does not cover reimbursable codes. Perhaps, if the section on Cultural-Bound Syndromes were given a more prominent place within the text and not stuck at the end, it might prove more useful. Still, it is noteworthy that a section on culture was included in the most recent revision of the DSM.

In addition to these issues, the DSM's idiosyncratic nature and lack of focus on the troublesome features of a social context have been associated with perpetuating the oppression of women and minorities (Loring & Powell, 1988). University counselors using the DSM-IV need to be keenly aware of the implications of psychodiagnosis, especially the impact that a particular diagnosis may have on a client's future - within and outside of the college environment. This was particularly evident in this writer's own college counseling center. A former student, applying for a job with the FBI, had given written permission for the agency to view the complete contents of her file in the student counseling center. Unfortunately, a diagnosis of clinical depression was formally noted, which almost cost the former student the job (though the FBI did hire her). This example highlights how the diagnostic system stigmatizes and potentially puts students at risk even years later. Any college or university counselor prescribing a diagnosis may be wise to warn the student being diagnosed that such a label could impact their future employability.

Although the DSM with its complex system of diagnoses and numbering system is not the only psychodiagnostic nomenclature in existence, it remains

the most popular and is unlikely to disappear anytime in the near future (Maser, Kaelbar, & Weise, 1991). It is this writer's hope that college and university counselors will continue to challenge the profession to continue a commitment toward a developmental, non-pathological approach to student mental health concerns. College and university counselors must remain vigilant in conveying a sense of the diagnostic system's shortcomings and strengths. Regardless of how the DSM system is viewed, the reality for college and university counselors is that many outside the college counseling center (e.g., psychiatrists, dean's of students, physicians, etc.) will continue to insist on its use. Thus, college and university counselors must be competent in their ability to understand and use the DSM-IV. College counseling center professionals must explore ways of adapting developmental approaches to DSM's psychiatric model. Given DSM's relative popularity, failure to do so could mean less viability for a college counseling center, and perhaps provide impetus to outsourcing counseling to off-campus resources (such as the local mental health clinic) or merger with the university health service (becoming very common), under the direction of a physician or other medical officer. In both scenario's, the developmental function of counseling likely could be lost.

While the DSM classification system is likely here to stay, a developmental approach may eventually lead to a diagnostic and classification model focusing on person-environment transactions (Ivey and Ivey, 1998). This might serve the function of both creating language that medical professionals and college counselors are comfortable with and presenting a more humanized face than the traditional medical model DSM system that is currently in place. It is the author's hope that the reader will find the ideas presented challenging, and work to ensure that the profession of college counseling remains committed to a positive developmental view of most student distress.

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“ *Do not the most moving
moments of our lives find us
all without words?* **”**

—MARCEL MARCEAU

An Empirical Study Of College Students' Grief Responses: Death vs. Non-death losses

Debra A. Cohen

This study examined grief responses to death and non-death losses. Two hundred and forty-two college students completed surveys assessing their responses to eight loss scenarios describing four death loss and four non-death loss events. Participants reported the intensity of distress, sense of loss, and grief they expected to experience, as well as whether they believed others would acknowledge their grief and whether they felt entitled to support. The results indicated that grief responses to non-death losses can result in symptoms seen with death losses. Further, a lack of acknowledgment of grief by others is associated with a lower incidence of help seeking. One important implication is that mental health professionals should broaden their conceptualization of loss.

Introduction

Grief is the fundamental reaction to losses and changes we encounter as we live and grow. Simply stated, grief is about the loss of anything that once was valued. Accordingly, changing jobs, retiring, moving, getting married, divorced or separated, developing an illness, loss of a person, a pet or a belief, having a miscarriage or abortion, ending a personal relationship, losing a valued possession, graduating, moving through developmental stages of life, changing an established lifestyle or status, leaving home, losing the ability to see or hear; losing a limb, having unmet personal needs, failing to reach personal goals, and even experiencing financial setbacks may result in grief behavior (Franken, 1996; LaGrand, 1981; Ruple, 1985).

Society typically associates grief with death loss events, yet fails to acknowledge non-death loss events as capable of causing similar physical and psychological distress. The empirical literature suggests that grief experi-

enced with non-traditional death and non-death loss events is viewed as insignificant by others and is not acknowledged or treated (Doka, 1989; Kaczmarek & Backlund, 1991; Lenhardt, 1997; Pine, 1972). Some researchers have described this phenomenon as " 'disenfranchised grief,'... grief that accompanies losses that are felt deeply by an individual who is grieving, but is given no socially recognized right or role to grieve" (Doka, 1987, p. 8). In this scenario, individuals may not feel entitled to assistance, and subsequently, may not seek informal support or formal counseling for the psychological and physical distress accompanying this grief.

As an example, consider that entry level college students may experience psychological distress associated with the changes and losses engendered by their transition from the home to the college environment. College students may exhibit psychological symptomatology such as shock, anxiety, sorrow, depression, withdrawal from others, an intense preoccupation with home, guilt, anger, tension, sleep and appetite disturbances (Collins & Sedlacek, 1973; LaGrand, 1983). These are symptoms which have been described in the professional literature as grief (Clayton, Halikas, & Maurice, 1971; Freese, 1977; Lindemann, 1944; Parkes, 1971).

Studies have indicated that non-death loss events have the potential to evoke very strong psychological and physical reactions for college students that may have serious and even life threatening implications (Collins, 1972; Kaczmarek, Backlund & Biemer, 1990; LaGrand, 1985, 1988; Pistole, 1995). Researchers have identified the break-up of a friendship or romantic relationship, failing a course and the divorce of parents as precipitating events to suicide among young adults (Adams, Overholser, & Spirito, 1994; Garland, 1994; Ladely & Puskar, 1994).

The present study examined how college students differentiate their grief experiences in response to death and non-death loss events. More specifically, this study investigated the grief responses of college students to various death and non-death loss events to determine how likely they were to acknowledge their experience of grief, feel entitled to and avail themselves of informal support or formal counseling.

Background and Methodology

Most of the literature on grief relates to death loss events, examining and identifying the psychological and physical outcomes of grief, and the factors that influence the incidence of normal and pathological grief. More recently however, grief responses following non-death loss events have begun to be examined. LaGrand's work (1981, 1985, 1986) stands alone in his research on college students and loss events. In an early study, LaGrand (1981) collected

lists of non-death losses experienced by college students ($N = 3,252$) at 16 colleges and universities over a period of six years. While LaGrand has identified a variety of non-death loss events and their respective physical, psychological, and emotional consequences for students, what remains unclear is whether college students interpret these events as grief-producing, whether others recognize and acknowledge their grief and, if so, whether students feel entitled to seek formal counseling and informal support to assist them through the process of grief resolution. Importantly, however, LaGrand (1981, 1985), concluded that the psychological and physical consequences of non-death loss events among students may equal or surpass consequences to those experiencing death loss events.

While the grief associated with death events has been extensively investigated, there exists a broad range of other stressful life events and non-death loss events that have not been a focus of investigation and may have serious physical, psychological and developmental consequences for grieving individuals. As a result of these gaps in the literature, as well as LaGrand's (1981, 1985, 1986) groundbreaking research, the intent of this study was to build on and extend our examination of college students and their experiences of grief. As such, six hypotheses were developed.

Hypothesis 1. Do college students' perceptions and experiences of grief differ for death loss vs. non-death loss events?

Hypothesis 2. Do college students feel that grief associated with death loss events is more likely to be acknowledged by others (members of their informal social network) than grief associated with non-death loss events?

Hypothesis 3. Do college students feel more entitled to seek informal support or formal counseling for death loss events than for non-death loss events?

Hypothesis 4. Do college students differ in their tendency to seek informal support or formal counseling for death loss events vs. non-death loss events?

Hypothesis 5. Do male and female college students differ in their grief responses to loss events?

Hypothesis 6. Are college students decisions to seek formal counseling following death and non-death loss events influenced by other independent variables; i.e. a sense of entitlement to seek formal counseling and recognition of the grief by others? Do these independent variables differ for death and non-death loss events?

College students' experience of grief and their likelihood of seeking informal support or formal counseling were assessed using a survey instrument adapted by the researcher from a questionnaire developed by Thornton,

Robertson, and Mlecko (1991). Thornton and colleagues assessed the reactions of undergraduate students ($N = 96$) to someone grieving a disenfranchised loss vs. someone grieving a traditional loss. Students read and responded to hypothetical scenarios and evaluated the severity of the grief experience, the suitability of engaging support services, the responses of others, and the interpersonal and social functioning of the grieving individual. In another study which examined grief experiences of college students, LaGrand (1985) asked undergraduate students to describe events in their lives which they considered to be losses. From this survey, he compiled a list of loss events experienced by college students.

For the present study, the researcher incorporated the list compiled by LaGrand (1985) into the format of the measurement instrument developed by Thornton and colleagues (1991). This adapted survey included 35 of the loss events identified by college students in the study by LaGrand (1985). It was administered to 12 mental health professionals at the Syracuse University Counseling Center in order to ascertain whether the survey had content and face validity. Based on their evaluation, questions were revised to facilitate comprehension and a total of eight scenarios were selected for inclusion in the Life Events Survey. Each hypothetical loss scenario was differentiated by changing the object of loss. The four death events chosen were the death of a parent, death of a friend or roommate, death of a teacher or coach, death of a pet. The four non-death loss events chosen were the end of a romantic relationship, termination from a position of employment, being cut from an athletic team, and experiencing the divorce of parents.

For each scenario included in the Life Events Survey, participants were asked to respond to questions which incorporated the various symptoms and emotional responses of grief as defined by Lindemann (1944). Specifically, participants were asked to read each hypothetical loss scenario and respond to questions regarding: (a) the intensity of feelings experienced in relationship to the event using a 7-point Likert scale with categories ranging from *Not at all intense* to *Most intense*, (b) whether the experience represented a "loss", (c) whether the participant felt that others acknowledged that they were grieving, and (d) whether the participant felt entitled and actually sought informal support or formal counseling using a 7-point Likert scale with categories ranging from *Never* to *Always*. For each of the eight hypothetical loss scenarios, participants also were required to indicate whether they had ever experienced the event prior to participating in this study.

Participants were also asked to complete a demographic questionnaire which requested the participant's age, gender, academic year, ethnicity, religion and both parents' age, education and occupational status. The demographic questionnaire also asked participants whether they had ever received formal counseling.

The first 32 students from the introductory psychology course who signed up to participate were included in the pilot study to test the survey instrument. The sociodemographic characteristics of participants in the pilot study approximated the general university demographics for undergraduates students. The students in the pilot study were debriefed by the researcher after completing the Life Events Survey. The information from the debriefing was used to modify the phrasing and organization of survey items.

A maximum of 35 students was permitted to sign up for each administration of the survey. There was a total of nine administration sessions. The researcher was present and followed a set of standard procedures at each session. A brief introduction to the research study was provided, and ample time allotted for questions by the participants. Participants were given a pre-numbered folder containing: (a) the "Life Events Survey," (b) the participant demographic questionnaire, (c) a participant consent form, and (d) a participant debriefing statement. Scenarios included in the Life Events Survey were counterbalanced to control for the impact that order may have had on participant responses.

All participants completed the Life Events Survey responding to four death loss scenarios and four non-death loss scenarios, as described above. For each scenario, the study participants used a Likert scale, ranging from 0 (*Not at all intense*) to 7 (*Most intense*).

Other questions asked participants to use a Likert scale ranging from 0 (*Never*) to 7 (*Always*) to rate whether: they would describe the event as a loss [*loss*]; the event would evoke feelings of grief [*grief*]; others would recognize and expect them to grieve as a result of the event [*expectation of others*]; they would feel entitled to seek informal support [*entitled informal*] or formal counseling [*entitled formal*]; and they would seek informal support [*seek informal*] or formal counseling [*seek formal*].

To examine student responses to these eight scenarios, results were analyzed for each scenario individually and for death and non-death scenarios as two separate groups. To calculate responses for death (non-death) events, a simple average was taken for responses to each question for the four death (non-death) events. Since there were no a priori grounds for weighting loss events differently, a simple average was deemed adequate. In order to examine differences in loss responses for men and women, a simple average of responses to all scenarios (global) was also calculated.

Prior to performing statistical analyses of the data, variables were created from individual items on the Life Events Survey as described in the previous section. The reliability of each of these variables was assessed using Cronbach's coefficient alpha. Alpha coefficients for non-death loss variables were ad-

equate (above .70) for all variables except loss and intensity. Reliability levels were generally lower for death losses with only three of the variables (seek informal, entitled formal, seek formal) having alpha coefficients greater than .70. The lower reliability scores for the death loss events suggest that, in contrast to the fact that society commonly groups traditional death loss events together and treats them as if they were all the same, not all death events are experienced similarly by participants. The alpha coefficients for all variables ranged from .85 to .87.

Results

Sociodemographic Characteristics

A total of 249 surveys were administered and collected. There were seven participants with missing data for at least one of the eight scenarios. They were not included in the statistical analyses because their mean death, non-death, and global ratings were not representative of all loss scenarios. The statistical analyses included the remaining 242 participants who completed the Life Events Survey.

The sample included 146 females (60%) and 96 males (40%). The ages of the respondents ranged from 17 to 23 (mean = 18.7 years, standard deviation = 1.09 years), and most (73%) participants reported that they had never received formal counseling.

Life Events Survey

Mean ratings for the death of a parent scenario were highest, indicating that students perceived this event as the most grief producing (reflected in their mean ratings for intensity, loss and grief variables) and reported feeling entitled to seek informal support or formal counseling. Mean ratings for the death of a friend scenario were also high in comparison to the other loss scenarios.

Interestingly, the third highest student ratings were assigned, not to a death loss event as one might expect, but to a non-death loss event, the divorce of parents. The mean ratings for parental divorce were higher than those reported for the death of a teacher/coach and the death of a pet scenario. The break-up of a relationship scenario evoked responses from students similar to those they indicated for the death of a teacher/coach and death of a pet scenarios with various fluctuations across variables (some variables were rated higher while others were lower).

Student mean ratings for the remaining non-death loss events included on the Life Events Survey [being cut from an athletic team and being terminated from a job] were the lowest. Yet, these non-death loss events still elicited mean ratings of three or higher for the intensity, loss and grief variables implying that non-death loss events have the potential to produce at least some grief symptomatology.

With respect to entitlement to seek informal support [entitled informal] and seeking informal support [seek informal], only the death of a parent scenario, death of a friend scenario and the divorce of parents scenario were events where students indicated that they would feel entitled to and seek informal support as evidenced by student mean ratings ranging from 5.3 to 6.6 for entitled informal and 4.5 to 5.8 for seek informal. All other loss scenarios were rated much lower by participants for these variables. With respect to entitlement to seek formal counseling [entitled formal] and seeking formal counseling [seek formal], mean ratings were low for all loss scenarios except the death of a parent. What this implies is that almost no students would seek formal counseling for the remaining loss scenarios. In essence, students felt that they must experience a major loss (death of a parent) before they would even consider seeking help and support.

These descriptive results confirm the notion that grief accompanying many non-death loss events are experienced by participants as disenfranchised, in the sense that students do not feel entitled to seek informal support or formal counseling, nor do they feel that others will recognize or acknowledge their grief.

Prior Experience of Loss Event

Participants were asked to report if they had prior experience with any or all of the hypothetical loss scenarios on the Life Events Survey. Those students who report prior experience of a particular loss event, it was thought, might respond differently to items on the Life Events Survey. For death loss events, 47% of the students reported prior experience with the death of a pet, 11% with the death of a teacher/coach, 5% with the death of a parent, and 2% with the death of a friend. For non-death loss events, 72% reported prior experience with the break-up of a relationship, 20% with the divorce of parents, 19% being cut from an athletic team, and 8% being terminated from a job. These descriptive summary statistics for prior experience of loss events reveal that participants were much more likely to experience a non-death loss event than a death loss event, much in line with their developmental life stage.

In order to determine whether prior experience of a loss event may have affected responses on the Life Events Survey two groups of students, those

who reported prior experience with a loss event and those who did not, were compared with respect to mean intensity, loss, grief and expectation of others using two sample t-tests. In general, there was little difference between mean ratings for the two student groups. Students with and without prior experience of a hypothetical loss event had comparable responses.

However, there were two significant differences between the groups. The mean intensity rating was significantly higher for students who had experienced the break-up of a relationship (mean = 5.5, standard error = .10) than for students who had not (mean = 4.9, standard error = .20, $p = .01$). The mean grief rating was significantly higher for students who had not been terminated from a job (mean = 3.2, standard error = .13) than for those who had (mean = 2.2, standard error = .49, $p = .04$). In all analyses, the standard error of the mean is provided as it assumes the role of the standard deviation.

Prior Use of Counseling

To examine the possible effect that student's prior use of formal counseling may have had on their responses to the counseling items on the Life Events Survey, students were asked if they had ever received formal counseling on the demographic questionnaire. Two-sample t-tests were then used to compare the two groups, (those who reported prior use of counseling and those who did not) for the entitlement [entitled informal, entitled formal] and seeking [seek informal, seek formal] variables.

For the death of a parent ($p = .00$), death of a friend ($p = .02$), break-up of a relationship ($p = .00$), and divorce of parents scenarios ($p = .01$) mean ratings for the variables entitled formal and seek formal were significantly higher for students who reported prior use of counseling than for students who reported no prior use of counseling. For the death of a parent ($p = .05$), death of a teacher/coach ($p = .01$), death of a pet ($p = .03$), and break-up of a relationship ($p = .03$) scenarios, mean ratings for the variable seek informal were also significantly higher for students who reported prior use of counseling.

Testing of Hypotheses

Hypothesis 1

The hypothesis that college students would assign higher ratings of (i) intensity, (ii) loss and (iii) grief to death loss events than to non-death loss events was tested using difference scores. The differences [death - non-death]

between each participants mean ratings of (i) intensity, (ii) loss, and (iii) grief were calculated and one-sample t-tests were used to test the hypothesis.

Table 1 summarizes the results of the within group comparisons. The mean difference scores for intensity, loss, and grief were statistically significantly different from zero ($p = .00$). Supporting hypothesis 1, mean intensity, loss, and grief ratings were higher for death loss events than for non-death loss events.

Table 1. Within Group Comparisons Intensity, Loss, and Grief

Variable	Mean $\pm$ SEM	p value
Intensity	0.70 $\pm$ 0.06	0.00
Loss	1.62 $\pm$ 0.08	0.00
Grief	1.71 $\pm$ 0.08	0.00

N = 242

Table entries for variables are mean standard error of the mean.

Dependent variable is the difference between a participant's mean ratings for death vs. non-death events.

p value is for the comparison between means using within-groups t-test

Specifically, the difference in mean ratings between death and non-death loss events exceeded 1.6 for the loss and grief variables. However, the difference decreased to less than 1 (0.7) for the intensity variable. Surprisingly, students appear to feel almost as strongly about the non-death loss events as death loss events, but are less apt to label non-death events as losses and recognize them as grief producing.

One possible interpretation for this finding is that students appear unwilling to acknowledge their grief unless they feel it is socially acceptable, even if they experience intense feelings of distress following the loss event.

Hypothesis 2

The hypothesis that college students would expect that friends, relatives, and others would be more likely to acknowledge grief associated with death loss events than with non-death loss events was tested using a one sample t-test of the difference score [death - non-death] for the variable expectation of others.

Table 2 summarizes the results of the within group comparisons. The mean difference was statistically significantly different from zero ($p = .00$). Mean ratings for expectation of others were higher for death loss events than for non-death loss events, thus supporting hypothesis 2.

Grief Responses: Death vs. Non-Death Losses

Table 2. Within Group Comparisons Expectation of Others

Variable	Mean $\pm$ SEM	p value
Expectation of Others	1.59 $\pm$ 0.08	0.00
N = 242		

Table entries for variables are mean standard error of the mean.

Dependent variable is the difference between a participant's mean ratings for death vs. non-death events.

p value is for the comparison between means using within-groups t-test.

The gap between death and non-death loss events for expectation of others is very close in magnitude to that for the loss and grief variables, adding further support to the possible association between the experience of grief and expectations of others about acceptable grief. As such, the recognition and acknowledgment of grief by others is a necessary and important component in the process of normal grief resolution.

Hypothesis 3

The hypotheses that college students would feel more entitled to (i) seek informal support and (ii) seek formal counseling for death loss events than for non-death loss events were tested using one sample t-tests of the difference scores [death - non-death] for the variables (i) seek informal and (ii) seek formal.

Table 3 summarizes the results of the within group comparisons. The mean difference scores for both entitled informal and entitled formal were statistically significantly different from zero ($p = .00$); mean ratings for entitled informal and entitled formal were higher for death loss events than for non-death loss events, supporting hypothesis 3.

Table 3. Within Group Comparisons Entitled Informal, and Entitled Formal

variable	Mean $\pm$ SEM	p value
Entitled Informal	1.02 $\pm$ 0.08	0.00
Entitled Formal	1.01 $\pm$ 0.07	0.00
N = 242		

Table entries for variables are mean standard error of the mean.

Dependent variable is the difference between a participant's mean ratings for death vs. non-death events.

p value is for the comparison between means using within-groups t-test.

Thus, there is a significant difference in how entitled students feel to seek services, formal or informal, for grief experienced as a result of a non-death loss event. This, once again, speaks directly to the notion of disenfranchised

grief. If students do not feel that grief is an socially acceptable response to a non-death loss event, they will not feel entitled to or seek informal social support or formal counseling. These findings reveal that college students feel more entitled to seek informal support or formal counseling in response to a death loss event simply because they have received "permission" to do so.

Hypothesis 4

Difference scores [death - non-death] were calculated for the variables (i) seek informal and (ii) seek formal. One sample t-tests of these difference scores were used to test the hypotheses that college student would be more likely to seek (i) informal support and (ii) formal counseling for death loss events than non-death loss events.

Table 4 summarizes the results of the within group comparisons. The mean difference scores for both variables were statistically significantly different from zero ($p = .00$). As expected, mean ratings for seek informal and seek formal were higher for death loss events than for non-death loss events. Interestingly, the actual difference in student ratings between death and non-death loss events was slightly higher for seeking informal support than for seeking formal counseling. Thus, students report that they are more apt to seek support from friends, relatives, and others than from mental health counselors. Collectively, these findings are somewhat disheartening. Despite the general availability of counseling on college campuses, a significant portion of the students nevertheless still reported that they would not seek formal counseling. Perhaps the stigma of seeking professional mental health services is still alive and well, as supported by the study data.

Table 4. Within Group Comparisons Seek Informal, and Seek Formal

variable	Mean $\pm$ SEM	p value
Seek Informal	1.00 $\pm$ 0.09	0.00
Seek Formal	0.89 $\pm$ 0.07	0.00

N = 242

Table entries for variables are mean standard error of the mean.

Dependent variable is the difference between a participant's mean ratings for death vs. non-death events.

p value is for the comparison between means using within-groups t-test.

Hypothesis 5

The a priori hypotheses of differences between males and females were stated in terms of all loss events. As a result, participants ratings for the four death scenarios and the four non-death scenarios were combined for these analyses. Two-sample t-tests were used to test the hypotheses of gender

differences with respect to mean ratings of intensity, loss, grief, seek informal, seek formal, entitled informal, and entitled formal. Gender differences for global intensity, loss, grief, expectation of others, entitled informal, entitled formal, seek informal, and seek formal variables were examined for all loss scenarios combined (global measures). Between group comparisons were used to determine whether the mean global ratings for all loss events were significantly different for males and females. The researcher found little difference in the mean global ratings for males and females for all loss scenarios, implying that men and women do not have distinctive patterns of grieving. It is interesting to note, however, that the mean global ratings of global entitled informal ($p = .01$) were statistically significantly higher for females than males (The data supporting this finding will be provided by the author upon request).

Given that men appear to be less likely to rely on informal support to assist them through the grieving process, this finding reaffirms the potential importance of developing outreach programs targeted at male college students to encourage them make use of informal supports and formal counseling services on university campuses.

Generally, there were no significant differences between males and females for all loss events. It may be that sex differences are apparent when separate comparisons are done for death loss and non-death loss events. In order to assess this possibility post-hoc comparisons between males and females were completed using a .01 level of significance ($\alpha = .01$). For death loss events, mean ratings of entitled informal were statistically significantly higher ($p = .00$) for females than for males. This result is consistent with the gender comparison for all loss events. The mean ratings of intensity and seek informal were also statistically significantly higher ($p = .01$) for females than males, suggesting that death loss events may evoke more grief behavior among females. There were no significant differences between males and females with respect to mean ratings for non-death loss events (The data supporting these findings will be provided by the author upon request). The finding of significant differences between males and females for death loss events but not for non-death loss events suggests that these events are distinct phenomena which should not be grouped together.

Hypothesis 6

Multiple regression analyses were used in order to test the hypothesis that a sense of entitlement, recognition of grief by others, and sociodemographic characteristics are important predictors of whether college students report that they would seek formal counseling for (i) death loss events and (ii) non-death loss events. A stepwise regression procedure (PROC STEPWISE, SAS)

was used to model the dependent variable seek formal using the independent variables: entitled formal, expectation of others, gender, age, prior counseling (yes, no), ethnicity (Caucasian, other), religion (Catholic, other) and father's and mother's education (less than a college education, college education).

Factors affecting students' willingness to seek formal counseling following death and non-death loss events, respectively, were examined through stepwise regression analysis. The regression analyses were completed separately for death loss and non-death loss events to determine whether there are different factors which predict the likelihood of seeking formal counseling following these two event categories. As expected, the variable entitled formal was the most statistically significant predictor ($p = .00$) of the variable seek formal for death loss events. Fifty-eight percent of the variance in the dependent variable, seek formal, was accounted for by the independent variable, entitled formal for death loss events. Although gender ($p = .02$) and age ($p = .02$) were also statistically significant predictors of the dependent variable, seek formal for death loss events, the contribution of the sociodemographic variables was small in comparison to that of the independent variable entitled formal. In fact, gender, age, prior use of counseling, and father's education accounted for only an additional 4% of the variance in the dependent variable seek formal (as indicated by the change in R^2) (The data supporting these findings will be provided by the author upon request).

The variable entitled formal was also a statistically significant predictor ($p = .00$) of the willingness of students to seek formal counseling for non-death events. Forty-six percent of the variance in the dependent variable, seek formal, was accounted for by the independent variable, entitled formal. Expectation of others ($p = .02$), gender ($p = .05$), and age ($p = .05$) were also statistically significant predictors of the dependent variable seek formal for non-death loss events. The contribution of both expectation of others and the sociodemographic variables of gender, age, and prior use of counseling were small in comparison to that of the independent variable entitled formal for non-death loss events (The data supporting these findings will be provided by the author upon request).

Overall, in contrast to death loss events, students appear to need reaffirmation from friends, relatives and others to validate their grief experienced subsequent to non-death loss events. This recognition from others seems to influence formal help seeking behaviors. This finding is consistent with the literature on disenfranchised grief which suggests that grief experienced from non-death loss events is often viewed as insignificant by others, and is not acknowledged or treated (Doka, 1989; Kaczmarek & Backlund, 1991; Pine, 1972). Some students appear to need permission from others to seek help for losses other than death.

Limitations of the Study

Certain limitations of the study warrant discussion. First, the present study was conducted using an analogue design to assess students' perceptions and experiences of grief. Thus, it is difficult to know if or how the data may generalize to more naturalistic assessments. Second, the ability of the survey instrument to adequately assess grief has not been empirically demonstrated. Third, the subject pool was comprised of mostly undergraduate freshmen attending a large private co-educational university.

Implications for Mental Health Counselors and Counselor Educators

The results of this study can have important implications for mental health counselors, counselor educators, and researchers. Continued professional development in this area is crucial if mental health counselors and counselor educators are to help others enfranchise the grief resulting from non-death losses, validate these experiences, encourage students to seek formal counseling and social support, and develop outreach programs. More specifically, mental health counselors and counselor educators should consider incorporating treatment models for grief, loss and bereavement as posited by theorists such as Bowlby (1961), Parkes (1971) and Kubler-Ross (1969) for college students who present with grief symptomatology.

Recommendations for Future Research

Continued research is needed to enhance the understanding of contributing factors and possible interventions strategies for grief resolution in non-death loss situations. The literature suggests that empirical measurement of the psychological consequences of grief and how the intensity of such psychological consequences vary may be a function of ethnic and cultural differences, previous and concurrent grief episodes, relationship with deceased or loss objects, and personality of the grieved prior to death or loss. Future research should explore the relationships among these factors.

Future research also should investigate counseling interventions which emphasize grief recognition and grief validation. Considerable effort should be made to develop assessment instruments with sound psychometric properties for screening, diagnosing, and treating grief for death and non-death loss experiences.

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Book Review

Power Plays: Their Use and Abuse in Human Relations (1998).

Gerald Alper, Bethesda, MD: International Scholars

Publications, 159 pages, \$34.95 cloth, \$24.95 paperback.

Reviewed by Daniel L. Araoz

Gerald Alper, a writer and psychoanalyst, has been recognized as a brilliant teacher of human interactions. As such, the *New England Review of Books* described his previous book, *Portrait of the Artist as a Young Patient* (1992) as "one of the most important modern studies of the psyche... (and) the creative personality." Alper uses psychoanalytic thinking in a down to earth manner without engaging in esoteric disquisition of arcane language.

According to Alper, power plays take place when there is a covert attempt to impose rules on the behavior of others merely for the benefit and satisfaction of the manipulation. His book successfully addresses the "dynamics of power transactions" by focusing on intrapsychic and interpersonal dynamics spanning from the parent to the child, through managerial interactions, to abusive and violent relationships.

Though primarily directed to the therapist for the enrichment of their relationships with clients, the book will also be of interest and value to the client. All readers will find that *Power Plays* contains useful guidelines and vignettes that will help them to identify and avoid abusive relational power games.

I wish to note that there were a few minor facets of *Power Plays* that could have improved its readability. First, it would have been easier to read if the font had been larger and the margins had been wider. Furthermore, the Index should have been more comprehensive. Finally, while Jay Haley (who had previously addressed power dynamics in relationships) was cited in the Preface, his contributions were not listed in the References. Nevertheless, at a time when manipulative power games abound at all levels of society, this book can contribute to the sanity and mental health of the country. Therefore, I enthusiastically recommend *Power Plays* to all counselors as well as to all who believe that personal growth is a life-long task.

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